

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04627

4640

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 1 day				d. STREET ADDRESS 1620 Ridge Place, S.E.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Convalescent and Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Ellsworth Last Allman				4. DATE OF DEATH Month April Day 13 Year 19 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76		IF UNDER 24 HRS. Hours 76 Min. 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lieutenant (retired) Fire Department				10b. KIND OF BUSINESS OR INDUSTRY Dis. of Columbia			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Allman				14. MOTHER'S MAIDEN NAME Louise Goss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Viola Allman; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 331X							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 13, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Sherman Bros.				24a. REC'D BY REGISTRAR 1661- Good Hope Rd SE WASH DC		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used and a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4651

CERTIFICATE OF DEATH

04628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 2006 Roanoke Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Alsop		4. DATE OF DEATH Month Day Year April 21 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20 1959
9. AGE (In years last birthday) yrs. 13		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John W. Alsop		14. MOTHER'S MAIDEN NAME Gloria J Auth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Gloria J Mother		Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration - Premature 7 mos (c) Alumytha Placenta (Cesarean Section)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 20 , 19 59 to April 21 , 19 59 that I last saw the deceased alive on April 21 , 19 59 , and that death occurred at 8:20 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED Hyattsville, Md. 4/21/59			
ACTUAL SIGNATURE Gordon W. Kelly M.D.		6124-41/1/59	
PHYSICIAN'S NAME (Type) Dr. Kelly		Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/22/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Name of Deceased _____		Date of Death _____	
Age of Deceased _____		Sex of Deceased _____	
Race of Deceased _____		Marital Status _____	
Place of Birth _____		Usual Residence _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4652
CERTIFICATE OF DEATH

04629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY First BOY Middle ATHEY Last		4. DATE OF DEATH Month 4 Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 1 Months 1 Days 1 Hours 1 Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Ervin Athey		14. MOTHER'S MAIDEN NAME Mary Donaldson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Mother		Address Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrops Fetalis 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Erythroblastosis Fetalis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 24 hr 24 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4-20 , 19 59 , to 4-21 , 19 59 , that I last saw the deceased alive on 4-21 , 19 59 , and that death occurred at 4:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.D. Bauer M.D.		ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd. Delphi, Md.	
NAME (Type) R.D. Bauer M.D.		DATE SIGNED 4-21-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/25/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr		24a. REC'D BY REGISTRAR DATE APR 30 '59	
ADDRESS Administrator		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		ARMY SERVICE		MARINE SERVICE		COAST GUARD SERVICE		OTHER SERVICE					
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		PREEXISTING DISEASE		ACUTE DISEASE		CHRONIC DISEASE		INFECTIOUS DISEASE		TOXIC DISEASE		TRAUMATIC DISEASE		OTHER DISEASE					
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF NOTARY		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF SURVIVOR		SIGNATURE OF HEIR		SIGNATURE OF ESTATE					

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REMARKS: (For use by the physician or coroner to record any special findings or conditions not covered by the above.)

TO BE FILLED IN BY THE PHYSICIAN OR CORONER

TO BE FILLED IN BY THE JURY

TO BE FILLED IN BY THE JUDGE

TO BE FILLED IN BY THE CLERK

TO BE FILLED IN BY THE REGISTRAR

TO BE FILLED IN BY THE NOTARY

TO BE FILLED IN BY THE WITNESS

TO BE FILLED IN BY THE DECEASED

TO BE FILLED IN BY THE SURVIVOR

TO BE FILLED IN BY THE HEIR

TO BE FILLED IN BY THE ESTATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4653

CERTIFICATE OF DEATH

Reg. Dist. No.

04630

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Lanham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 19344 Annapolis Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Karl J. Austin		First Middle Last		4. DATE OF DEATH April 27 1959		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1887	
9. AGE (In years last birthday) 72 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXX Ret.		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME William Austin				14. MOTHER'S MAIDEN NAME Emily Glazier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Wife-Mrs. Virginia M. Austin-As above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Chronic Urinary tract infection, Proplegia (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 wks Indefinite	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 to 4-27 1959, that I last saw the deceased alive on 4-26 1959, and that death occurred at 12:35 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE D. R. Purdie M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Lanchis Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE APR 29 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4654

CERTIFICATE OF DEATH

Reg. Dist. No.

04631

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Ball		4. DATE OF DEATH Month Day Year April 28 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Mar. 1885
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John James Sweeney	
14. MOTHER'S MAIDEN NAME Martha E. Warfield		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT W. Howard Ball	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 Subacute Bacteraemia Torsemia DUE TO (b) Subacute Bacteraemia infectio. splem DUE TO (c) + alcohol in infection sec. to sept. embol. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-23, 1959, to 4-28, 1959, that I last saw the deceased alive on 4-28, 1959, and that death occurred at 7:31 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Ronald Fleischer, M.D.		ADDRESS (Street, city or town, state) 5432 Queens Chapel Rd. DATE SIGNED 7/28/59	
PHYSICIAN'S NAME (Type) Dr. Ronald Fleischer, Md.		1440 Hatteras Rd.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hall's Funeral Home, Inc.		ADDRESS Mt. Rainier, Md.	
24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

This image shows a vertical strip of a document page. It features two large, solid black circular marks, one near the top and one near the bottom, which appear to be punch holes or significant damage to the paper. The background is a light, textured gray with some faint, illegible text visible through the paper.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04632

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH-OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kendallworth Beaver Heights	
3. NAME OF DECEASED (Type or print) First Middle Last Cesare Baroni		4. DATE OF DEATH Month Day Year April 26 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. XX 26 19 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Barber	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mary Y. Baron; same address as # 2.	
17. INFORMANT Mary Y. Baron; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 26	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-59	
22c. NAME OF CEMETERY OR CREMATORY Washington Nat Cent.		22d. LOCATION (City, town, or county) (State) Switzland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee Sons		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Krawe	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John A. [illegible]		SEX Male	
AGE 45		DATE OF BIRTH [illegible]	
PLACE OF BIRTH [illegible]		OCCUPATION [illegible]	
MARITAL STATUS Married		PLACE OF DEATH [illegible]	
DATE OF DEATH July 20, 1930		TIME OF DEATH 11:15 A.M.	
CAUSE OF DEATH Acute congestive heart failure		MANNER OF DEATH Natural	
MEDICAL HISTORY [illegible]		SOCIAL HISTORY [illegible]	
PHYSICAL EXAMINATION [illegible]		LABORATORY EXAMINATIONS [illegible]	
SIGNATURE OF EXAMINER [illegible]		SIGNATURE OF WITNESS [illegible]	

4706

CERTIFICATE OF DEATH

Reg. Dist. No.

04633

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS 1676 32nd St NW			
3. NAME OF DECEASED (Type or print) First Middle Last ROYDEN EUGENE BEEBE JR				4. DATE OF DEATH Month Day Year APRIL 29 19 59			
5. SEX MALE	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 July 1908	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maj Gen USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) Fort Douglas, Utah		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Royden E. Beebe, Sr.				14. MOTHER'S MAIDEN NAME Sarah Reid Park			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1932 to 1959		16. SOCIAL SECURITY NO. 579-52-9072		17. INFORMANT Wife Mrs. Royden E. Beebe Jr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Instantaneous 6 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 April, 19 59, to 29 April, 19 59, that I last saw the deceased alive on _____, 19 _____, and that death occurred at 5:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Thomas G Briggs				M.D. USAF Hospital Andrews 29 April 1959			
PHYSICIAN'S NAME (Type) THOMAS G BRIGGS, CAPT, USAF (MC)				Andrews AFB, Wash 25, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 4, 1959		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME				ADDRESS 816 H St, N.E. WASH, DC.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
This is to certify that the within report was made by a duly qualified person and that the same is true and correct to the best of his knowledge and belief.
J. Edgar Hoover
Director

CERTIFICATE OF DEATH

6306

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

NAME OF DECEASED J. Edgar Hoover		SEX Male		AGE 57	
DATE OF BIRTH Jan 22, 1894		PLACE OF BIRTH Washington, D.C.		OCCUPATION Director	
DATE OF DEATH Jan 22, 1951		PLACE OF DEATH Washington, D.C.		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several months	
EDUCATION Bachelor's Degree		RELIGION Methodist		MARRIAGE Married	
FATHER'S NAME John Edgar Hoover		MOTHER'S NAME Ida Louise Hoover		FAMILY HISTORY None	
DATE OF INTERMENT Jan 22, 1951		PLACE OF INTERMENT Arlington National Cemetery		FUNERAL HOME None	
SIGNATURE OF REGISTRAR J. Edgar Hoover		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None	

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4707

CERTIFICATE OF DEATH

04634

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Bruce Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Bruce Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4450 White Hall Rd Washington 23</u>				d. STREET ADDRESS <u>near Metwood, Md</u>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Lee</u> Last <u>Binger</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 5 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Prince Georges Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Benj. F. Duckett</u>				14. MOTHER'S MARRIED NAME <u>Rebecca Kingsbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Fred K Binger</u> Address <u>Upper Marlboro Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arteriosclerotic Myocarditis</u> DUE TO <u>unknown</u> (c) <u>General Arteriosclerosis</u> DUE TO <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic hypertensive Arthritis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Suitland</u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Jan 11 1959</u> to <u>April 15 1959</u> , that I last saw the deceased alive on <u>April 15 1959</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE Washington 28 DC</u> DATE SIGNED <u>4/16/59</u>							
ACTUAL SIGNATURE <u>Paul C Van Vatta</u> M.D.				PHYSICIAN'S NAME (Type) <u>PAUL C VAN VATT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Suitland Md.</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u> ADDRESS <u>Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>	

1995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 7014 Varnum Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES HENRY Middle BLACK Last				4. DATE OF DEATH Month April Day 14, Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1877		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk				10b. KIND OF BUSINESS OR INDUSTRY Post Office Dept		11. BIRTHPLACE (State or foreign country) Salem, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Hannah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Spanish Amer. no		17. INFORMANT Florence M. Black		Address 7014-Varnum St. Landover Hills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PROSTATIC HYPERTROPHY + PYELONEPHRITIS DUE TO (c) # PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACIDOSIS INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 6 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 19 Month, Day, Year p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from 4/12/59 to 4/14/59 , that I last saw the deceased alive on 4/13/59 , and that death occurred at 4:41 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert Roth M.D.				ADDRESS (Street, city or town, state) Reverdale, Md. DATE SIGNED 4/14/59			
PHYSICIAN'S NAME (Type) Dr. Albert Roth, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-1959		22c. NAME OF CEMETERY OR CREMATORY Scottdale Cemetery		22d. LOCATION (City, town, or county) (State) Scottdale, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home - Mt. Rainier, Md.				ADDRESS Sne.		24a. REC'D BY REGISTRAR DATE APR 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kane			

CERTIFICATE OF DEATH

DECEASED'S NAME [Name]		SEX [Male/Female]		RACE [Race]		DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]	
DECEASED'S RESIDENCE [Address]		DECEASED'S OCCUPATION [Occupation]		DECEASED'S MARITAL STATUS [Married/Single/etc.]		DECEASED'S RELIGION [Religion]		DECEASED'S EDUCATION [Education]	
DECEASED'S SOCIAL SECURITY NUMBER [Number]		DECEASED'S MOTHER'S MAIDEN NAME [Name]		DECEASED'S FATHER'S NAME [Name]		DECEASED'S BIRTH DATE [Date]		DECEASED'S BIRTH PLACE [Place]	
DECEASED'S DEATH DATE [Date]		DECEASED'S DEATH TIME [Time]		DECEASED'S DEATH PLACE [Place]		DECEASED'S DEATH CAUSE [Cause]		DECEASED'S DEATH MANNER [Manner]	
DECEASED'S DEATH CERTIFICATE NUMBER [Number]		DECEASED'S DEATH CERTIFICATE DATE [Date]		DECEASED'S DEATH CERTIFICATE PLACE [Place]		DECEASED'S DEATH CERTIFICATE TIME [Time]		DECEASED'S DEATH CERTIFICATE MANNER [Manner]	

10

DECEASED'S NAME
 [Name]
 SEX
 [Male/Female]
 RACE
 [Race]
 DATE OF BIRTH
 [Date]
 PLACE OF BIRTH
 [Place]
 DECEASED'S RESIDENCE
 [Address]
 DECEASED'S OCCUPATION
 [Occupation]
 DECEASED'S MARITAL STATUS
 [Married/Single/etc.]
 DECEASED'S RELIGION
 [Religion]
 DECEASED'S EDUCATION
 [Education]
 DECEASED'S SOCIAL SECURITY NUMBER
 [Number]
 DECEASED'S MOTHER'S MAIDEN NAME
 [Name]
 DECEASED'S FATHER'S NAME
 [Name]
 DECEASED'S BIRTH DATE
 [Date]
 DECEASED'S BIRTH PLACE
 [Place]
 DECEASED'S DEATH DATE
 [Date]
 DECEASED'S DEATH TIME
 [Time]
 DECEASED'S DEATH PLACE
 [Place]
 DECEASED'S DEATH CAUSE
 [Cause]
 DECEASED'S DEATH MANNER
 [Manner]
 DECEASED'S DEATH CERTIFICATE NUMBER
 [Number]
 DECEASED'S DEATH CERTIFICATE DATE
 [Date]
 DECEASED'S DEATH CERTIFICATE PLACE
 [Place]
 DECEASED'S DEATH CERTIFICATE TIME
 [Time]
 DECEASED'S DEATH CERTIFICATE MANNER
 [Manner]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4708

CERTIFICATE OF DEATH

04636
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB Wash 25, DC				c. LENGTH OF STAY IN 1b 15 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Una Middle Lester Last Boyles				4. DATE OF DEATH Month April Day 24 Year 19 59			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 6, 1902	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Clerk				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Wyley Bridges				14. MOTHER'S MAIDEN NAME Docia Elvira Suttle Fournute			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Ralph Cordovan				Address 8 Oriley Drive, Clinton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 24, 1959 , to April 24, 1959 , that I last saw the deceased alive on April 24, 1959 , and that death occurred at 4:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF Hospital Andrews DATE SIGNED April 24, 1959							
ACTUAL SIGNATURE Reginald P McManus				PHYSICIAN'S NAME (Type) REGINALD P. MC MANUS CAPT USAF (MC) Andrews AFB., Washington 25, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4.27. 1959		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees, Sr.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE APR 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04637

Reg. Dist. No.

4657

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General		e. STREET ADDRESS 5704-29th. Place	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARIE C. BRADLEY	First Middle Last	4. DATE OF DEATH April 3, 1959	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Hooper	
14. MOTHER'S MAIDEN NAME Lillian Burns		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur Bradley 7930-18th. Ave. Adelphi Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardio Vascular Renal Heart Disease (c) Cardio Vascular Renal Heart Disease DUE TO (a) stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED April 4, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-7-'59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 5801-Cleve. Ave. Riverdale		24. REGISTRAR'S SIGNATURE Arthur L. Finney	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF HEALTH EXAMINER
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John J. Jones		45		Male		White		10-1-1933	
Place of Death		Cause of Death		Manner of Death		Disease or Injury		Signature of Examiner	
Home		Heart Disease		Natural		Coronary Artery Sclerosis		J. H. Smith	
Occupation		Residence		Marital Status		Previous Illnesses		Date of Examination	
Teacher		123 Main St.		Married		Hypertension		10-1-1933	
Education		Religion		Usual Habits		Alcohol Consumption		Signature of Coroner	
High School		Catholic		Sobriety		Occasional		W. D. Brown	
Previous Injuries		Other Remarks		Signature of Physician		Date of Death		Signature of Medical Examiner	
None		None		J. H. Smith		10-1-1933		J. H. Smith	

4709

CERTIFICATE OF DEATH

04638

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 3 yrs., 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 666 Kenilworth Ave., N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jack Middle Brown Last Brown				4. DATE OF DEATH Month April Day 29 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/4/1882	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Oklahoma				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Brown				14. MOTHER'S MAIDEN NAME Ellen Tillman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 200-07-3310		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONITIS RT MIDDLE + LOWER LOBES Pulmonary emphysema and fibrosis; cor pulmonale;				INTERVAL BETWEEN ONSET AND DEATH 14 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/18/59 to 4/29/59 , that I last saw the deceased alive on 4/29/59 , and that death occurred on 4/29/59 at 10:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Moe Weiss				ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 4/29/59			
PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-4-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Palmer Funeral Home				ADDRESS 412-H St, NE, Wash, D.C.		24a. REC'D BY REGISTRAR DATE MAY 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04639

Reg. Disf. No.

4710

FOR STATE
HEALTH DEPT.

H

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4534 Wheeler Rd SE</u>		d. STREET ADDRESS <u>4534 Wheeler Road</u>	
3. NAME OF DECEASED (Type or print) <u>Richard C. Brown</u>		4. DATE OF DEATH <u>April 6 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/09</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salmon</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Estelle Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes. I W W II</u>		16. SOCIAL SECURITY NO. <u>1 W W II</u>	
17. INFORMANT <u>Sarah J. Brown - S.E. Wash., D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Universal burns of body - Charring</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of home that burned to ground</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-6 1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Oxon Hill</u> (County) <u>Pr. Geo.</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/10/59</u>		22b. DATE THEREOF <u>4/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Va.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mason</u> ADDRESS <u>2500 Nichols Ave, S.E. #17</u>		24a. REC'D BY REGISTRAR <u>APR 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN EXAMINED BY THE PHYSICIAN IN CHARGE OF THE STATE HOSPITAL AND FOUND TO BE A CASE OF TUBERCULOSIS OF THE LUNGS AND IS THEREFORE A CONTAGIOUS CASE AND IS BEING KEPT IN THE HOSPITAL FOR THE PRESENT.

JAMES I. Boyd

James I. Boyd

Admitted 7.1.1922

Admitted 4.1.22

21-22

Immune to scarlet fever - healthy

Admitted 12.1.22

Admitted 12.1.22

Admitted 12.1.22

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04640

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b Dead on arrival Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5007 Southern Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert First William Middle Brownlee Last		4. DATE OF DEATH Month April Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert William Brownlee		14. MOTHER'S MAIDEN NAME Frances Leatherwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT Ethel King Brownlee, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 30, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		24a. REC'D BY REGISTRAR DATE MAY 1 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4659

CERTIFICATE OF DEATH

04641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (27) Seat Pleasant d. STREET ADDRESS 7010 Greig Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Bryant		4. DATE OF DEATH Month Day Year April 6 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/59
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Billy C. Bryant		14. MOTHER'S MAIDEN NAME Sally Maxine Firestone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 7547	
17. INFORMANT Sally Bryant Mother		Address Address same	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 7547 DUE TO Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocarditis (c) Acute Myocarditis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3 , 19 59 , to April 6 , 19 59 that I last saw the deceased alive on April 6 , 19 59 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John Kehoe		ADDRESS (Street, city or town, state) DATE SIGNED Cheverly, Md. 4/6/59	
PHYSICIAN'S NAME (Type) Dr. John Kehoe		Cheverly, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 4/9/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr		ADDRESS Administrator.	
24a. REC'D BY REGISTRAR APR 13 59		24b. REGISTRAR'S SIGNATURE Arthur L. Thoms	

2077252XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

202

100

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108-- Park Blvd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Silver Hill	
3. NAME OF DECEASED (Type or print) First FLORA Middle M. Lost BRYANT		4. DATE OF DEATH Month Apr. 28th Day 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1895
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse-Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph M. Armiger		14. MOTHER'S MAIDEN NAME Agnes V. Atwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard A. Bryant		Address 108-- Park Blvd. Silver Hill, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 13 years +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1946, to April 27, 1959, that I last saw the deceased alive on April 28, 1959, and that death occurred at 11:45 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE James C. Cawood		M.D. 2520 Pa. Ave S.E. Washington, DC 4/24/59	
PHYSICIAN'S NAME (Type) JAMES C. CAWOOD		2520 Pa. Ave. S.E. Washington DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1st, 1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James Busby		ADDRESS 1661--Good Hope Rd., SE Washington 20, DC	
24a. REC'D BY REGISTRAR DATE APR 30 '59		24b. REGISTRAR'S SIGNATURE C. L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 45		DATE OF BIRTH Jan 15 1866	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Single		COLOR White	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Baltimore, Md.	
DATE OF DEATH Jan 15 1911		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	
SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF NEXT OF KIN J. H. Harris	
SIGNATURE OF BURIAL OFFICER J. H. Harris		SIGNATURE OF MINISTER J. H. Harris	
SIGNATURE OF REGISTRAR J. H. Harris		SIGNATURE OF CLERK J. H. Harris	

1911

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

04643

Reg. Dist. No.

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill			
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 6796 Tucker Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	3. NAME OF DECEASED (Type or print) Catherine E. Buckler			4. DATE OF DEATH Month Apr. Day 20 Year 19 59				
	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/06	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Langley				14. MOTHER'S MAIDEN NAME Julia Ida Langley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Lula May Chaney 5018- 25th. Place S.E.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Breast with Gen. Metastasis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from Apr. 13 , 19 59 , to Apr. 20 , 19 59 , that I last saw the deceased alive on Apr. 20 , 19 59 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Bernard F. Peacock M.D. 2324 Emerson St. S.E. H. H. East Hough PHYSICIAN'S NAME (Type) Bernard F. Peacock Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.		
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros				ADDRESS 1661 Laurel Hape Rd SE		24a. REC'D BY REGISTRAR DATE APR 22 '59		
						24b. REGISTRAR'S SIGNATURE Arthur E. Thomas		

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04644

Reg. Dist. No.

4661

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4704 Edmonston Road			d. STREET ADDRESS 2505 Rhode Island Ave N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Planter First Bush Middle Last			4. DATE OF DEATH April 27 19 59 Month Day Year		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-4-08		9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron worker		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Bush			14. MOTHER'S MAIDEN NAME Sally Peal		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 420-12-3310		15. INFORMANT John Walker; 1507 R.I. Avenue, Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hemorrhage from duodenal ulcer (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 27, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-59		22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL	
22d. LOCATION (City, town, or county) (State) SWITLAND, MARYLAND		23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Inc. Washington DC		24a. REC'D BY REGISTRAR MAY 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Film G242 5-14-59 et
4712 CERTIFICATE OF DEATH

04645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>		c. LENGTH OF STAY IN 1b <u>22 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sandy Spring Road</u>		d. STREET ADDRESS <u>Sandy Spring Road</u>	
3. NAME OF DECEASED (Type or print) <u>John Edward Castle Sr.</u>		4. DATE OF DEATH <u>April 29 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emanuel Martin Castle</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes WW I</u>		16. SOCIAL SECURITY NO. <u>212-32-6508</u>	
17. INFORMANT <u>Mr. Clarence Castle</u>		Address <u>Laurel Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/23</u> , 19 <u>59</u> , to <u>4/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/29</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. P. Warren</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Md</u> DATE SIGNED <u>4/30/59</u>	
PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ing Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sk Witt Canale</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>MAY 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9, Film G241, 4/14/59 fcy
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

04646

Reg. Dist. No.

4662

1. PLACE OF DEATH a. COUNTY Prince George, b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Murdirk d. STREET ADDRESS 6100 Murdirk Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adeline First Middle Last Coleman		4. DATE OF DEATH April 4 19 59 Month Day Year	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 28, 1882
9. AGE (In years last birthday) 77 7/16 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isral Crump		14. MOTHER'S MAIDEN NAME Elizabeth Swale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Brother Irsal Crump Jr. 6118 Murdirk Rd, Murdirk, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1958, to 4-4 1959, that I last saw the deceased alive on 4-2 1959, and that death occurred at 10:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas R. Mazzocco M.D.		ADDRESS (Street, city or town, state) 320 Montgomery, Laurel, Md 49-59 DATE SIGNED	
PHYSICIAN'S NAME (Type) THOMAS R. MAZZOCCO			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-8-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Queens Chapel Cem, Murdirk, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		ADDRESS -467-71 St NW	
24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

CERTIFICATE OF DEATH

1933

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12

NAME OF DECEASED William J. ...		SEX Male	
AGE 45		DATE OF BIRTH Jan 1, 1888	
PLACE OF BIRTH Boston, Mass.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE Dec 1, 1910	
NAME OF SPOUSE Mary E. ...		PLACE OF MARRIAGE Boston, Mass.	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Boston, Mass.	
DATE OF DEATH Dec 1, 1933		TIME OF DEATH 10:00 AM	
SIGNATURE OF PHYSICIAN J. H. ...		SIGNATURE OF REGISTRAR ...	
SIGNATURE OF WITNESS ...		SIGNATURE OF WITNESS ...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04647

Reg. Dist. No.

4663

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 5417 McBeth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Susan May Collins			4. DATE OF DEATH Month April Day 7 Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1880		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Dressmaker		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME Joseph Kirbo			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles B. Collins; same address as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, diabetes.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 7, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 4/9/59		22c. NAME OF CEMETERY OR CREMATORY Alanta	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 10 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
100 STATE STREET, ROOM 100
BOSTON, MASSACHUSETTS 02109
TELEPHONE 725-1234

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED		FATHER		MOTHER	
Name		Name		Name	
Age		Age		Age	
Sex		Sex		Sex	
Race		Race		Race	
Date of Birth		Date of Birth		Date of Birth	
Place of Birth		Place of Birth		Place of Birth	
Usual Residence		Usual Residence		Usual Residence	
Date of Death		Date of Death		Date of Death	
Place of Death		Place of Death		Place of Death	
Cause of Death		Cause of Death		Cause of Death	
Manner of Death		Manner of Death		Manner of Death	
Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner	
Date of Signature		Date of Signature		Date of Signature	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04648

Reg. Dist. No.

4649

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. LENGTH OF STAY IN 1b 1 year	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Raimier		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2901 Arundel Road			d. STREET ADDRESS 2901 Arundel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Eleanor Evelyn Crouch			4. DATE OF DEATH Month Day Year April 25 1959		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-75		9. AGE (in years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas Padgett		
14. MOTHER'S MAIDEN NAME Mary Rockett			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Hattie P. Crouch; same address as # 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 25, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/59		22c. NAME OF CEMETERY OR CREMATORY Congressional	
22d. LOCATION (City, town, or county) Washington, DC		22e. (State) DC			
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Mt Rainier Inc.		ADDRESS md.		24a. REC'D BY REGISTRAR DATE APR 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

FOR STATE
HEALTH DEPT.

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St.		Farmer		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
Jan 15, 1918		10:00 AM		Home		Dr. Smith	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Physician	
Jan 16, 1918		11:00 AM		Home		Dr. Smith	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4713

Reg. Dist. No. 04649

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Junction of 301 and 50			d. STREET ADDRESS Route # 450		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard Boyd Dale			4. DATE OF DEATH Month April Day 18 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 5, 1938		9. AGE (In years last birthday) 20 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Skilled		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Theodore Dale			14. MOTHER'S MAIDEN NAME Carrie Viola Mann		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-26-3729		17. INFORMANT Personal Papers On body Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed skull DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupnat of an automobile that was in a collision with another/			
20c. TIME OF INJURY Month, Day, Year 6:40 P.M. 4/18/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Place of death	
				20f. (City or town) (County) (State) Mitchellville P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 18, 1959	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF April 21/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			4739 Baltimore Ave. Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE APR 21 '59
					24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hous</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4714

CERTIFICATE OF DEATH

04650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Fort Foote)</u>				c. LENGTH OF STAY IN 1b <u>7 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7823 Fort Foote Rd S.E.</u>				d. STREET ADDRESS <u>7823 Fort Foote Rd S.E.</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Davis</u>				4. DATE OF DEATH <u>April 27 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1865</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife Georgetown, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank Schaefer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mary Thorne</u> Address <u>7823 Fort Foote Rd S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Senility & Art-Sclerotic Gangrene of feet.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left hip - Non-Union 6-6-53</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-6-53</u> to <u>4-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-27</u> , 19 <u>59</u> , and that death occurred at <u>4:45 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7519 Broadview Rd S.E. Washington D.C.</u> DATE SIGNED <u>4/27/59</u>							
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D.				PHYSICIAN'S NAME (Type) <u>ANNA COYNE TODD</u> <u>Friendly, Md (D.C. 22)</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>April 29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Bire</u> ADDRESS <u>1661-20th Hope Rd. Wash 20 D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4664

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5436 McBeth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel Lucy Dawson		4. DATE OF DEATH Month April Day 14 Year 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Press		14. MOTHER'S MAIDEN NAME Gertrude Drake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Kenneth A. Browning; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 4/16/59		22b. DATE THEREOF 4/16/59	
22c. NAME OF CEMETERY OR CREMATORY Shinglehouse		22d. LOCATION (City, town, or county) (State) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE APR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Examiner	
9. Signature of Physician		10. Signature of Coroner		11. Signature of Medical Examiner		12. Signature of Registrar	
13. Signature of Undertaker		14. Signature of Burial Place		15. Signature of Cemetery		16. Signature of Funeral Home	
17. Signature of Family		18. Signature of Friends		19. Signature of Neighbors		20. Signature of Community	
21. Signature of Church		22. Signature of School		23. Signature of Business		24. Signature of Government	
25. Signature of Other		26. Signature of Other		27. Signature of Other		28. Signature of Other	
29. Signature of Other		30. Signature of Other		31. Signature of Other		32. Signature of Other	
33. Signature of Other		34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other		40. Signature of Other	
41. Signature of Other		42. Signature of Other		43. Signature of Other		44. Signature of Other	
45. Signature of Other		46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other		52. Signature of Other	
53. Signature of Other		54. Signature of Other		55. Signature of Other		56. Signature of Other	
57. Signature of Other		58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other		64. Signature of Other	
65. Signature of Other		66. Signature of Other		67. Signature of Other		68. Signature of Other	
69. Signature of Other		70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other		76. Signature of Other	
77. Signature of Other		78. Signature of Other		79. Signature of Other		80. Signature of Other	
81. Signature of Other		82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other		88. Signature of Other	
89. Signature of Other		90. Signature of Other		91. Signature of Other		92. Signature of Other	
93. Signature of Other		94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other		100. Signature of Other	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please "execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie		c. LENGTH OF STAY IN 1b 39 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ritchie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7000 White House Rd SE				d. STREET ADDRESS 17000 White House Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virgil Cleveland Dixon				4. DATE OF DEATH April 4 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 1, 1884	
				9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY German		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Benjamin Dixon				14. MOTHER'S MAIDEN NAME Susan Phipps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 818-38-5068		17. INFORMANT Mrs. Maud Dixon, Danvers # ✓	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 4, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Chittenden Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc				ADDRESS 577 11th St S.E.		24a. REC'D BY REGISTRAR APR 7 '59	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

2

STATE
OF OHIO

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
COLUMBUS, OHIO

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HENRY		45		M		W		JAN 15 1910	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
COLUMBUS, OHIO		COLUMBUS, OHIO		HEART DISEASE		NATURAL		COLUMBUS, OHIO	
OCCUPATION		EDUCATION		MARITAL STATUS		RELIGION		SIGNED	
CLERK		HIGH SCHOOL		MARRIED		METHODIST		J. H. HENRY	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF MEDICAL EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNED		DATE	
J. H. HENRY		JAN 15 1910		COLUMBUS, OHIO		J. H. HENRY		JAN 15 1910	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4665

CERTIFICATE OF DEATH

Reg. Dist. No. 04653

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X N. Forestville.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 3401 Boones Lane	
3. NAME OF DECEASED (Type or print) First Middle Last Mary ANN Donaldson		4. DATE OF DEATH Month Day Year April 18 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 27-1894
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Donaldson		14. MOTHER'S MAIDEN NAME Clara B. Donaldson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Patricia Sears, 3401 Boones Lane, S.E. D. C.		Address Washington	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis, Left mid Cerebral Artery 6 Days (c) arteriosclerosis, Cerebral Arteries 1 year Hypertensive - Arteriosclerosis HEART 1 year		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 1959, to April 18, 1959, that I last saw the deceased alive on April 18, 1959, and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel Sugar M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4300 KAYWOOD DRIVE 4/18/59 MT RAINIER, Md.	
PHYSICIAN'S NAME (Type) Dr. Samuel Sugar			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chubbuck		ADDRESS 517 11th S.E. D.C.	
24a. REC'D BY REGISTRAR APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4666

CERTIFICATE OF DEATH

Reg. Dist. No. 04654

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Milton Last Dotson		4. DATE OF DEATH Month April Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 May 1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George M. Dotson		14. MOTHER'S MAIDEN NAME Jane Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Margaret E. Dotson		Address Westwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HT FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HT DISEASE DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/2 19 59 , to 4/2 19 59 , that I last saw the deceased alive on 4/2 19 59 , and that death occurred at 6:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John K. Kibre M.D.		ADDRESS (Street, city or town, state) 3404 Sherrwood Ave	
PHYSICIAN'S NAME (Type) John K. Kibre		DATE SIGNED APR 7 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/59	
22c. NAME OF CEMETERY OR CREMATORY St. Thomas		22d. LOCATION (City, town, or county) (State) Aguasco Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR APR 7 '59	
ADDRESS Waldorf, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

NAME OF DECEASED [Faint handwritten name]		PLACE OF BIRTH [Faint handwritten place]	
SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]	
PLACE OF DEATH [Faint handwritten place]		NAME OF PHYSICIAN [Faint handwritten name]	
NAME OF FUNERAL HOME [Faint handwritten name]		NAME OF MINISTER [Faint handwritten name]	
NAME OF BURIAL PLACE [Faint handwritten name]		NAME OF CEMETERY [Faint handwritten name]	
NAME OF NEXT OF KIN [Faint handwritten name]		NAME OF WITNESS [Faint handwritten name]	
NAME OF REGISTRAR [Faint handwritten name]		NAME OF CLERK [Faint handwritten name]	

RECEIVED BY
 [Faint handwritten text]
 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4638

CERTIFICATE OF DEATH

Reg. Dist. No.

04655

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>	
c. LENGTH OF STAY IN 1b <i>since May 1958</i>		d. STREET ADDRESS <i>19507-50th Place</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9507-50th Place</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Maudie Foy Drum</i>		4. DATE OF DEATH <i>4-18-1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/7, 1889</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR: Months <i>4</i> Days <i>18</i> Hours <i>18</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	
11. BIRTHPLACE (State or foreign country) <i>Pulaski, Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Billie Daniels</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lee Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>0969</i>	
17. INFORMANT <i>Mabel C. Holloway</i>		Address <i>above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> DUE TO <i>0969</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Virus Infection</i> DUE TO <i>1 wk.</i> (c) <i>Coronary Heart Disease</i> DUE TO <i>1 yr.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 54</i> to <i>April 18, 1959</i> , that I last saw the deceased alive on <i>April 18, 1959</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. Osmon Barr M.D.</i>		ADDRESS (Street, city or town, state) <i>900 17th St. N.W.</i>	
PHYSICIAN'S NAME (Type) <i>E. Osmon Barr M.D.</i>		DATE SIGNED <i>4/18/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/20/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Henryville, Tenn.</i>		22d. LOCATION (City, town, or county) (State) <i>Henryville, Tenn.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home, Inc.</i>		ADDRESS <i>10th Kaiman</i>	
DATE REC'D BY REGISTRAR <i>APR 21 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thoms</i>	

CERTIFICATE OF DEATH

04656

Reg. Dist. No.

4716

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB., Wash 25 DC				c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS 1697 31st Street NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Betty Middle Elaine Last Dunn		4. DATE OF DEATH Month April Day 21 Year 19 59					
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH December 5, 1923		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sheryl I. Blake			14. MOTHER'S MAIDEN NAME Mabel Lee Scrutchfield				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 499165386		17. INFORMANT Address William E. Dunn 1697 31st St., Washington 7, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Glioblastoma multiform DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 days 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 14, 1959, to April 21, 1959, that I last saw the deceased alive on April 21, 1959, and that death occurred at 10:00AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital Andrews April 21 1959							
ACTUAL SIGNATURE Sanford L. Billet		M.D. USAF Hospital Andrews		April 21 1959			
PHYSICIAN'S NAME (Type) SANFORD L. BILLET CAPT USAF (MC) Andrews AFB., Washington 25, DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/59		22c. NAME OF CEMETERY OR CREMATORY Morrisdale Cemetery		22d. LOCATION (City, town, or county) (State) Morrisdale Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 Ga. Ave. N.W.		24c. REC'D BY REGISTRAR DATE MAY 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04657

Reg. Dist. No.

4650

1. PLACE OF DEATH a. COUNTY <u>PR, GEO.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PR, GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RAINIER</u>		c. LENGTH OF STAY in lb. <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4020-37 st-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM PENN EARNEST</u>		4. DATE OF DEATH Month <u>APR.</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUL 25-1903</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u>	
11. BIRTHPLACE (State or foreign country) <u>M.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>M.S.A</u>	
13. FATHER'S NAME <u>Wm Penn Earnest sr</u>		14. MOTHER'S MAIDEN NAME <u>Emma May Millhiser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>70</u>	
17. INFORMANT <u>Cassie L. Earnest - Mt Rainier Ind</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>FEB 23, 1959</u> to <u>APR 16, 1959</u> , that I last saw the deceased alive on <u>APR 13, 1959</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin M. Grassgreen</u> M.D.		ADDRESS (Street, city or town, state) <u>3101 ARUNDEL RD, MT. RAINIER, MD.</u>	
NAME (Type) <u>IRVIN M. GRASSGREEN</u>		DATE SIGNED <u>4/16/59</u>	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) _____ (State) _____ <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR <u>APR 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6550

FILE NO. 114

1. NAME OF DECEASED
JAMES HENRY JONES

2. SEX
Male

3. AGE
38

4. DATE OF BIRTH
Jan 15 1927

5. PLACE OF BIRTH
Baltimore, Md.

6. OCCUPATION
None

7. CAUSE OF DEATH
Heart Disease

8. MANNER OF DEATH
Natural

9. PLACE OF DEATH
Home

10. DATE OF DEATH
Jan 15 1965

11. TIME OF DEATH
10:00 AM

12. SIGNATURE OF DECEASED
None

13. SIGNATURE OF WITNESSES
None

14. SIGNATURE OF PHYSICIAN
None

15. SIGNATURE OF CORONER
None

16. SIGNATURE OF JURY
None

17. SIGNATURE OF JUDGE
None

18. SIGNATURE OF CLERK
None

19. SIGNATURE OF REGISTRAR
None

20. SIGNATURE OF DECEASED
None

21. SIGNATURE OF WITNESSES
None

22. SIGNATURE OF PHYSICIAN
None

23. SIGNATURE OF CORONER
None

24. SIGNATURE OF JURY
None

25. SIGNATURE OF JUDGE
None

26. SIGNATURE OF CLERK
None

27. SIGNATURE OF REGISTRAR
None

28. SIGNATURE OF DECEASED
None

29. SIGNATURE OF WITNESSES
None

30. SIGNATURE OF PHYSICIAN
None

31. SIGNATURE OF CORONER
None

32. SIGNATURE OF JURY
None

33. SIGNATURE OF JUDGE
None

34. SIGNATURE OF CLERK
None

35. SIGNATURE OF REGISTRAR
None

36. SIGNATURE OF DECEASED
None

37. SIGNATURE OF WITNESSES
None

38. SIGNATURE OF PHYSICIAN
None

39. SIGNATURE OF CORONER
None

40. SIGNATURE OF JURY
None

41. SIGNATURE OF JUDGE
None

42. SIGNATURE OF CLERK
None

43. SIGNATURE OF REGISTRAR
None

44. SIGNATURE OF DECEASED
None

45. SIGNATURE OF WITNESSES
None

46. SIGNATURE OF PHYSICIAN
None

47. SIGNATURE OF CORONER
None

48. SIGNATURE OF JURY
None

49. SIGNATURE OF JUDGE
None

50. SIGNATURE OF CLERK
None

51. SIGNATURE OF REGISTRAR
None

52. SIGNATURE OF DECEASED
None

53. SIGNATURE OF WITNESSES
None

54. SIGNATURE OF PHYSICIAN
None

55. SIGNATURE OF CORONER
None

56. SIGNATURE OF JURY
None

57. SIGNATURE OF JUDGE
None

58. SIGNATURE OF CLERK
None

59. SIGNATURE OF REGISTRAR
None

60. SIGNATURE OF DECEASED
None

61. SIGNATURE OF WITNESSES
None

62. SIGNATURE OF PHYSICIAN
None

63. SIGNATURE OF CORONER
None

64. SIGNATURE OF JURY
None

65. SIGNATURE OF JUDGE
None

66. SIGNATURE OF CLERK
None

67. SIGNATURE OF REGISTRAR
None

68. SIGNATURE OF DECEASED
None

69. SIGNATURE OF WITNESSES
None

70. SIGNATURE OF PHYSICIAN
None

71. SIGNATURE OF CORONER
None

72. SIGNATURE OF JURY
None

73. SIGNATURE OF JUDGE
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74. SIGNATURE OF CLERK
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75. SIGNATURE OF REGISTRAR
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76. SIGNATURE OF DECEASED
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77. SIGNATURE OF WITNESSES
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78. SIGNATURE OF PHYSICIAN
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79. SIGNATURE OF CORONER
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80. SIGNATURE OF JURY
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81. SIGNATURE OF JUDGE
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82. SIGNATURE OF CLERK
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83. SIGNATURE OF REGISTRAR
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84. SIGNATURE OF DECEASED
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85. SIGNATURE OF WITNESSES
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86. SIGNATURE OF PHYSICIAN
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88. SIGNATURE OF JURY
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89. SIGNATURE OF JUDGE
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90. SIGNATURE OF CLERK
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91. SIGNATURE OF REGISTRAR
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92. SIGNATURE OF DECEASED
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93. SIGNATURE OF WITNESSES
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94. SIGNATURE OF PHYSICIAN
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95. SIGNATURE OF CORONER
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96. SIGNATURE OF JURY
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97. SIGNATURE OF JUDGE
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98. SIGNATURE OF CLERK
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99. SIGNATURE OF REGISTRAR
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100. SIGNATURE OF DECEASED
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101. SIGNATURE OF WITNESSES
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102. SIGNATURE OF PHYSICIAN
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103. SIGNATURE OF CORONER
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104. SIGNATURE OF JURY
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105. SIGNATURE OF JUDGE
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106. SIGNATURE OF CLERK
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107. SIGNATURE OF REGISTRAR
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108. SIGNATURE OF DECEASED
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109. SIGNATURE OF WITNESSES
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110. SIGNATURE OF PHYSICIAN
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111. SIGNATURE OF CORONER
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112. SIGNATURE OF JURY
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113. SIGNATURE OF JUDGE
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114. SIGNATURE OF CLERK
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115. SIGNATURE OF REGISTRAR
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116. SIGNATURE OF DECEASED
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117. SIGNATURE OF WITNESSES
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118. SIGNATURE OF PHYSICIAN
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119. SIGNATURE OF CORONER
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120. SIGNATURE OF JURY
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121. SIGNATURE OF JUDGE
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122. SIGNATURE OF CLERK
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123. SIGNATURE OF REGISTRAR
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124. SIGNATURE OF DECEASED
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125. SIGNATURE OF WITNESSES
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126. SIGNATURE OF PHYSICIAN
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127. SIGNATURE OF CORONER
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128. SIGNATURE OF JURY
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129. SIGNATURE OF JUDGE
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130. SIGNATURE OF CLERK
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131. SIGNATURE OF REGISTRAR
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132. SIGNATURE OF DECEASED
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133. SIGNATURE OF WITNESSES
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134. SIGNATURE OF PHYSICIAN
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135. SIGNATURE OF CORONER
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136. SIGNATURE OF JURY
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137. SIGNATURE OF JUDGE
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138. SIGNATURE OF CLERK
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139. SIGNATURE OF REGISTRAR
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140. SIGNATURE OF DECEASED
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141. SIGNATURE OF WITNESSES
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145. SIGNATURE OF JUDGE
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146. SIGNATURE OF CLERK
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147. SIGNATURE OF REGISTRAR
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148. SIGNATURE OF DECEASED
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149. SIGNATURE OF WITNESSES
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150. SIGNATURE OF PHYSICIAN
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151. SIGNATURE OF CORONER
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152. SIGNATURE OF JURY
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153. SIGNATURE OF JUDGE
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154. SIGNATURE OF CLERK
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155. SIGNATURE OF REGISTRAR
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156. SIGNATURE OF DECEASED
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157. SIGNATURE OF WITNESSES
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160. SIGNATURE OF JURY
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161. SIGNATURE OF JUDGE
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162. SIGNATURE OF CLERK
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163. SIGNATURE OF REGISTRAR
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164. SIGNATURE OF DECEASED
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165. SIGNATURE OF WITNESSES
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166. SIGNATURE OF PHYSICIAN
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168. SIGNATURE OF JURY
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169. SIGNATURE OF JUDGE
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170. SIGNATURE OF CLERK
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171. SIGNATURE OF REGISTRAR
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172. SIGNATURE OF DECEASED
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173. SIGNATURE OF WITNESSES
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174. SIGNATURE OF PHYSICIAN
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175. SIGNATURE OF CORONER
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176. SIGNATURE OF JURY
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177. SIGNATURE OF JUDGE
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178. SIGNATURE OF CLERK
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179. SIGNATURE OF REGISTRAR
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181. SIGNATURE OF WITNESSES
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185. SIGNATURE OF JUDGE
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186. SIGNATURE OF CLERK
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187. SIGNATURE OF REGISTRAR
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188. SIGNATURE OF DECEASED
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189. SIGNATURE OF WITNESSES
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190. SIGNATURE OF PHYSICIAN
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191. SIGNATURE OF CORONER
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192. SIGNATURE OF JURY
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193. SIGNATURE OF JUDGE
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194. SIGNATURE OF CLERK
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195. SIGNATURE OF REGISTRAR
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196. SIGNATURE OF DECEASED
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197. SIGNATURE OF WITNESSES
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198. SIGNATURE OF PHYSICIAN
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199. SIGNATURE OF CORONER
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200. SIGNATURE OF JURY
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201. SIGNATURE OF JUDGE
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202. SIGNATURE OF CLERK
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203. SIGNATURE OF REGISTRAR
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204. SIGNATURE OF DECEASED
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205. SIGNATURE OF WITNESSES
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206. SIGNATURE OF PHYSICIAN
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207. SIGNATURE OF CORONER
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208. SIGNATURE OF JURY
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209. SIGNATURE OF JUDGE
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210. SIGNATURE OF CLERK
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211. SIGNATURE OF REGISTRAR
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212. SIGNATURE OF DECEASED
None

213. SIGNATURE OF WITNESSES
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214. SIGNATURE OF PHYSICIAN
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215. SIGNATURE OF CORONER
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216. SIGNATURE OF JURY
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217. SIGNATURE OF JUDGE
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218. SIGNATURE OF CLERK
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219. SIGNATURE OF REGISTRAR
None

220. SIGNATURE OF DECEASED
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221. SIGNATURE OF WITNESSES
None

222. SIGNATURE OF PHYSICIAN
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223. SIGNATURE OF CORONER
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224. SIGNATURE OF JURY
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225. SIGNATURE OF JUDGE
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226. SIGNATURE OF CLERK
None

227. SIGNATURE OF REGISTRAR
None

228. SIGNATURE OF DECEASED
None

229. SIGNATURE OF WITNESSES
None

230. SIGNATURE OF PHYSICIAN
None

231. SIGNATURE OF CORONER
None

232. SIGNATURE OF JURY
None

233. SIGNATURE OF JUDGE
None

234. SIGNATURE OF CLERK
None

235. SIGNATURE OF REGISTRAR
None

236. SIGNATURE OF DECEASED
None

237. SIGNATURE OF WITNESSES
None

238. SIGNATURE OF PHYSICIAN
None

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04658

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5411 Sargent Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ernest		First William		Middle Foerster		Last	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-6-96	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired plant accountant Telephone Co.				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Ernest Foerster				14. MOTHER'S MAIDEN NAME Marie Loeffler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Helen Foerster; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion and edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Cardiovascular renal disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John J. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 14, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/59		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				24a. REC'D BY REGISTRAR APR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04659

Reg. Dist. No.

4667

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1115 50th St., N.E.	
3. NAME OF DECEASED (Type or print) First William Middle Odell Last Fox		4. DATE OF DEATH Month April Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH 1-25-1921	9. AGE (In years last birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Wesley Fox		14. MOTHER'S MAIDEN NAME Janet Fitzgerald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 242-10-2418	
17. INFORMANT Van Fox		Address 1208 50th St., N.E. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of abdomen DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person.	
20c. TIME OF INJURY Month, Day, Year 6-15-59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> a home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chapel Oaks, Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1959	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn cemetery		22d. LOCATION (City, town, or county) Washington (State) D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. ADDRESS 3015 12th St., N. E.		24a. REC'D BY REGISTRAR APR 6 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Wilcox	
Sex		Male	
Age		41	
Date of Birth		April 2, 1900	
Place of Birth		Washington	
Usual Residence		1115 2nd St. N.E.	
Cause of Death		Hemorrhage and shock	
Manner of Death		Suicide	
Occupation		None	
Signature of Physician		J. T. Wilcox	
Signature of Medical Examiner		J. T. Wilcox	
Date of Death		April 2, 1941	
Place of Death		Home	
Signature of Coroner		J. T. Wilcox	
Signature of Registrar		J. T. Wilcox	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4668 CERTIFICATE OF DEATH

Reg. Dist. No.

04660

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaverly		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chaverly			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 3015 Lake Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle (N.M.N.) Last Gagne				4. DATE OF DEATH Month 4 Day 10 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/79		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Taunton, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis X. Poirier				14. MOTHER'S MAIDEN NAME Rosalie Lemoyne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Delia A. Donatelli, 3015 Lake Ave., Chaverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH immed. 1 wk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1959 , to April 10, 1959 , that I last saw the deceased alive on April 10, 1959 , and that death occurred at 8PM M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon W. Kelley		ADDRESS (Street, city or town, state) DATE SIGNED M.D. 6124-41st Ave. Hyattsville, Md 4/11/59					
PHYSICIAN'S NAME (Type) Gordon W. Kelley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. RECEIVED BY REGISTRAR APR 14 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

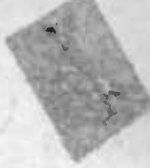
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1968

10

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
ADDRESS OF DECEASED [Illegible]		ADDRESS OF DEATH REGISTRAR [Illegible]		ADDRESS OF WITNESS [Illegible]	
CITY [Illegible]		COUNTY [Illegible]		STATE [Illegible]	
ZIP CODE [Illegible]		TELEPHONE [Illegible]		FAX [Illegible]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4669

CERTIFICATE OF DEATH

04661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 9th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Gant Last T				4. DATE OF DEATH Month April Day 11 Year 19 59			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 12 1912		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Howard Co Md		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME ERNEST GIBSON				14. MOTHER'S MAIDEN NAME Lavinia Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles Gantt 9th St Laurel			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10 , 19 59 , to April 11 , 19 59 , that I last saw the deceased alive on April 11 , 19 59 , and that death occurred at 9:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon W Kelley				ADDRESS (Street, city or town, state) DATE SIGNED 6124-46th Ave Hyattsville 4/11/59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial April 15 1959		Beacons Chapel		Arneaus Rd		Princ Georges	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgely Selby Laurel Md				24b. REC'D BY REGISTRAR DATE APR 16 59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4670

CERTIFICATE OF DEATH

04662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 1 5022 56th Place.	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Gardner		4. DATE OF DEATH Month Day Year April 23 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 April 1959
9. AGE (In years lost birthday) yrs. 22		10. IF UNDER 1 YEAR Months Days Hours Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T Gardner		14. MOTHER'S MAIDEN NAME JoAnn Higgins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 Resorption from atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/5/52 to 2/5/59 that I last saw the deceased alive on 2/5/52, 1959, and that death occurred at 2:15 A.M. from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE John Kehoe M.D.		ADDRESS (Street, city or town, state) Cheverly Md.	
PHYSICIAN'S NAME (Type) Dr. John Kehoe M.D.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 4/27/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE APR 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2077276XV6

CERTIFICATE OF DEATH

1915

Form 1-15

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15, 1870	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PLACE OF DEATH	
1234 Main St., Baltimore, Md.		Carpenter		Heart Disease		Home	
DATE OF DEATH		TIME OF DEATH		PLACE OF INTERMENT		NAME OF CLERGYMAN	
Jan 20, 1915		10:30 AM		Catholic Cemetery		Rev. J. J. Smith	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith	

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15, 1870	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PLACE OF DEATH	
1234 Main St., Baltimore, Md.		Carpenter		Heart Disease		Home	
DATE OF DEATH		TIME OF DEATH		PLACE OF INTERMENT		NAME OF CLERGYMAN	
Jan 20, 1915		10:30 AM		Catholic Cemetery		Rev. J. J. Smith	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4671

CERTIFICATE OF DEATH

04663
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George c. LENGTH OF STAY IN TB Langley Park		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 1733 Keokee Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert William Garwood		4. DATE OF DEATH Month Day Year Apr. 14 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1917
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10b. KIND OF BUSINESS OR INDUSTRY Printer	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles R. Garwood		14. MOTHER'S MAIDEN NAME Orpha Spoor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 313-10-9897	
17. INFORMANT Grizzelle R. Garwood (Wife)		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 min. 3 years.			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8, 1957 , to 4/14 , 1957, that I last saw the deceased alive on 4/14 , 1957, and that death occurred at 10:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. E. Musser		DATE SIGNED 4/14/59	
PHYSICIAN'S NAME (Type) F. E. Musser, M.D.		ADDRESS (Street, city or town, state) 4410 74th Ave. Landover Hills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/17/59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE APR 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. 12

1. Name of deceased: **JOHN J. ROBERTS**

2. Sex: **Male**

3. Age: **68**

4. Date of birth: **March 15, 1891**

5. Place of birth: **St. Louis, Mo.**

6. Race: **White**

7. Usual residence: **1705 Keeble Court**

8. Date of death: **April 10, 1959**

9. Time of death: **10:30 AM**

10. Cause of death: **Myocardial Infarction**

11. Duration of illness: **2 days**

12. Place of death: **Home**

13. Name of physician: **Dr. J. H. Smith**

14. Name of funeral home: **None**

15. Name of informant: **John J. Roberts**

16. Signature of physician: **[Signature]**

17. Signature of informant: **[Signature]**

18. Date of filing: **April 15, 1959**

19. Name of registrar: **John J. Roberts**

20. Name of registrar: **John J. Roberts**

21. Name of registrar: **John J. Roberts**

22. Name of registrar: **John J. Roberts**

23. Name of registrar: **John J. Roberts**

24. Name of registrar: **John J. Roberts**

25. Name of registrar: **John J. Roberts**

26. Name of registrar: **John J. Roberts**

27. Name of registrar: **John J. Roberts**

28. Name of registrar: **John J. Roberts**

29. Name of registrar: **John J. Roberts**

30. Name of registrar: **John J. Roberts**

31. Name of registrar: **John J. Roberts**

32. Name of registrar: **John J. Roberts**

33. Name of registrar: **John J. Roberts**

34. Name of registrar: **John J. Roberts**

35. Name of registrar: **John J. Roberts**

36. Name of registrar: **John J. Roberts**

37. Name of registrar: **John J. Roberts**

38. Name of registrar: **John J. Roberts**

39. Name of registrar: **John J. Roberts**

40. Name of registrar: **John J. Roberts**

41. Name of registrar: **John J. Roberts**

42. Name of registrar: **John J. Roberts**

43. Name of registrar: **John J. Roberts**

44. Name of registrar: **John J. Roberts**

45. Name of registrar: **John J. Roberts**

46. Name of registrar: **John J. Roberts**

47. Name of registrar: **John J. Roberts**

48. Name of registrar: **John J. Roberts**

49. Name of registrar: **John J. Roberts**

50. Name of registrar: **John J. Roberts**

51. Name of registrar: **John J. Roberts**

52. Name of registrar: **John J. Roberts**

53. Name of registrar: **John J. Roberts**

54. Name of registrar: **John J. Roberts**

55. Name of registrar: **John J. Roberts**

56. Name of registrar: **John J. Roberts**

57. Name of registrar: **John J. Roberts**

58. Name of registrar: **John J. Roberts**

59. Name of registrar: **John J. Roberts**

60. Name of registrar: **John J. Roberts**

61. Name of registrar: **John J. Roberts**

62. Name of registrar: **John J. Roberts**

63. Name of registrar: **John J. Roberts**

64. Name of registrar: **John J. Roberts**

65. Name of registrar: **John J. Roberts**

66. Name of registrar: **John J. Roberts**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04664

4672

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights- Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 5006 56th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle Arthur Last Givens			4. DATE OF DEATH Month April Day 25 Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-92		9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Iron Co.		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William A. Givens			14. MOTHER'S MAIDEN NAME Malinda Durham		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Jack A. Givens; 6209 54th Avenue Riverdale, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion</p> <p>420.1 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) Coronary thrombosis</p> <p>(c) Cardiovascular renal disease</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or MOVEMENT (Specify) Burial		22b. DATE THEREOF 4/27/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
22d. LOCATION (City, town, or county) (State) Colmar Manor Md.		23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE APR 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Howard					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St.		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
April 15, 1912		10:30 AM		Home		Dr. Smith	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Witness		Witness		Witness		Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		Physician	
April 16, 1912		11:00 AM		Home		Dr. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4717

CERTIFICATE OF DEATH

04665

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Pr Geos Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr Geos Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>		c. LENGTH OF STAY IN 1b <u>42</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant Md.</u>		d. STREET ADDRESS <u>606 - 62nd Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>606 - 62nd Place -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Adeline</u> Last <u>Godfrey</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Seltzer</u>		14. MOTHER'S MAIDEN NAME <u>Lemora Facer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mildred Armstrong - 606-62nd Pl Seat Pleasant Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>12 Hours</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs</u> <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13</u> , 19 <u>49</u> , to <u>April 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>59</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Suit Ritchie</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7005 Ritchie Road SE (4/22/59)</u>	
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie M.D.</u>		<u>Wash 27 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		4739 Baltimore Ave. <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

4718

CERTIFICATE OF DEATH

Reg. Dist. No. 04666

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Cedar Heights	
d. NAME OF HOSPITAL (If not a hospital, give street address) None		d. STREET ADDRESS 16467-K 16 St. NE	
3. NAME OF DECEASED (Type or print) Nellie		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/25 1874	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Residence		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Mary Alice Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Nellie C. Montgomery Address 723 W. 16th St. NE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DIS. (c) Generalized ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC DEMENTIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 10 1958 to April 16 1959, that I last saw the deceased alive on April 16 1959, and that death occurred at 6:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4112 G. Grant St. NE DATE SIGNED 4/16/59	
ACTUAL SIGNATURE Robert R. Nelson		M.D. MASH 19 DC	
PHYSICIAN'S NAME (Type) Robert R. Nelson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros. 621 Fla. Ave NW		24a. REC'D BY REGISTRAR DATE APR 21 '59	
		24b. REGISTRAR'S SIGNATURE Arthur A. Brand	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

04667
Reg. Dist. No.

4719

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE None b. COUNTY None			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 25, DC				c. LENGTH OF STAY IN 1b 10 Hrs 55 Min			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) None Washington 20, D. C. 47x-3				d. STREET ADDRESS None 3353 - 23rd St., S. E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kevin Middle --- Last Hayes				4. DATE OF DEATH Month April Day 16 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16 1959	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Rogers Hayes				14. MOTHER'S MAIDEN NAME Louise Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father 3353 23rd Street SE Washington 20, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 Hrs 55 Min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 16, 19 59, to April 16, 19 59, that I last saw the deceased alive on April 16, 19 59, and that death occurred at 11:30 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Douglas E. Pierce M.D.				ADDRESS (Street, city or town, state) USAF Hospital Andrews DATE SIGNED 16 Apr 59			
PHYSICIAN'S NAME (Type) DOUGLAS E. PIERCE CAPT USAF (MC)				Andrews AFB., Washington 25, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/23/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) H. Myers Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson Jenkins				ADDRESS 4804 Pa. Ave.		24a. REC'D BY REGISTRAR DATE APR 24 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

2050212X2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		MEMPHIS, TENN.	
5. OCCUPATION		6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH	
MEMBER OF CONGRESS		APRIL 4, 1968		4:00 PM		MEMPHIS, TENN.	
9. CAUSE OF DEATH		10. MANNER OF DEATH		11. PLACE OF INTERMENT		12. SIGNATURE OF REGISTRAR	
HEART DISEASE		NATURAL		MEMPHIS, TENN.		JAMES EARL RAY	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

(C)

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness, or by the coroner or other qualified person who has examined the body of the deceased after death. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health, Baltimore, Maryland, as soon as possible after death. This certificate is to be used for the purpose of determining the cause of death and for the purpose of determining the manner of death. It is to be filled out in duplicate, one copy to be filed with the local health department or the State Department of Health, Baltimore, Maryland, and the other copy to be filed with the local health department or the State Department of Health, Baltimore, Maryland.

4720

CERTIFICATE OF DEATH

04668

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROOM</u>		c. LENGTH OF STAY IN 1b <u>24 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>STAR ROUTE BOX 40 UPPER MARLBORO MD</u>		d. STREET ADDRESS <u>STAR ROUTE BOX 40 UPPER MARLBORO</u>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>HENSON</u> Last <u>N</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12 1931</u>
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>WILLIAM HENSON</u>	
14. MOTHER'S MAIDEN NAME <u>ADELINA HENSON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>ELLEN VICTORIA HENSON (WIFE)</u> Address <u>STAR ROUTE BOX 40 UPPER MARLBORO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>INANITION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u> <u>3 YRS</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>JAN. 1957</u> , to <u>APRIL 7, 1959</u> , that I last saw the deceased alive on <u>APRIL 7, 1959</u> , and that death occurred at <u>12:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Everett W. Cadenhall</u> M.D.		ADDRESS (Street, city or town, state) <u>3904 ELN ST.</u> DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>EVERETT W. CADENHALL JR. UPPER MARLBORO MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>4-18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Simon Episcopal Chapel Croom</u>		22d. LOCATION (City, town, or county) <u> </u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington & Sons</u> ADDRESS <u>467-77 St. N.W.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 241 4-22-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04669

4673

1. PLACE OF DEATH a. COUNTY Prince Georges County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN b 2 Hr 10 Min 15		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY PG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, MD		d. STREET ADDRESS 4708 66th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Michael		First		Middle		Last		4. DATE OF DEATH 4		Month		Day		Year 19 59					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/58		9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 14 Days 2		IF UNDER 24 HRS. Hours 4 Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jack Leroy Jacobs						14. MOTHER'S MAIDEN NAME Barbarra Overstreet													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Jack L. Jacobs (father)				Address above address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral far 16 DUE TO (c) Asp. gastritis embolus												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No accident or injury involved															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 8, 1959 , to April 9, 1959 , that I last saw the deceased alive on April 9, 1959 , and that death occurred at 7:35 P.M. from the causes and on the date stated above.																			
ACTUAL SIGNATURE John W. Perkins				M.D. 5301 Hamlet St. Hyattsville, MD				ADDRESS (Street, city or town, state)				DATE SIGNED 4/10/59							
PHYSICIAN'S NAME (Type) Dr. John Perkins																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Apr. 13, 1959				22c. NAME OF CEMETERY OR CREMATORY National Memorial Park				22d. LOCATION (City, town, or county) (State) Falls Church, Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.								ADDRESS				24a. REC'D BY REGISTRAR DATE APR 13 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1527

(L) " " " " "

1997-2000: 100% (100%)

04670

4642

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville MD</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Rainier, MD.</u>				d. STREET ADDRESS <u>5801-42 ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hyattsville Convalescent & Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>James</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabin man - Navy yard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg - Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John S. James</u>				14. MOTHER'S MAIDEN NAME <u>Indiana V. Malone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes Spanish War</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Agatha Murray</u> Address <u>(sister)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u> <u>? YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL ARTERIOSCLEROSIS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12 APRIL 1959</u> to <u>SAME</u> 19 <u>59</u> , that I last saw the deceased alive on <u>12 APRIL</u> 19 <u>59</u> , and that death occurred at <u>1:05 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>905 SHERIDAN ST. HYATTSVILLE</u> DATE SIGNED <u>4/12/59</u> ACTUAL SIGNATURE <u>Henry R. Wolfe</u> M.D. PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Philip		4. DATE OF DEATH April 21 19 59	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Jenifer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive ht failure (b) Atherosclerotic ht disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4/1, 1959, to 4/21, 1959, that I last saw the deceased alive on 4/20, 1959, and that death occurred at 1:35 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE John Kehoe		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. John Kehoe		ADDRESS (Street, city or town, state) Hyattsville Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) H-25-59		22b. DATE THEREOF 4-25-59	
22c. NAME OF CEMETERY OR CREMATORY St. Marys County		22d. LOCATION (City, town, or county) (State) md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred. or Funeral Home		ADDRESS 389-R.T. Ave. N.W.	
24a. REC'D BY REGISTRAR DATE APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF CLERK		23. SIGNATURE OF CHIEF OF POLICE		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF TOWNSHIP CLERK		26. SIGNATURE OF COUNTY CLERK		27. SIGNATURE OF STATE CLERK	
28. SIGNATURE OF FEDERAL CLERK		29. SIGNATURE OF POSTAL CLERK		30. SIGNATURE OF TELEPHONE CLERK	
31. SIGNATURE OF RAILROAD CLERK		32. SIGNATURE OF AIRLINE CLERK		33. SIGNATURE OF MARINE CLERK	
34. SIGNATURE OF NAVY CLERK		35. SIGNATURE OF ARMY CLERK		36. SIGNATURE OF AIR FORCE CLERK	
37. SIGNATURE OF SPACE CLERK		38. SIGNATURE OF ATOMIC CLERK		39. SIGNATURE OF NUCLEAR CLERK	
40. SIGNATURE OF COSMOS CLERK		41. SIGNATURE OF GALAXY CLERK		42. SIGNATURE OF UNIVERSE CLERK	
43. SIGNATURE OF COSMOS CLERK		44. SIGNATURE OF GALAXY CLERK		45. SIGNATURE OF UNIVERSE CLERK	
46. SIGNATURE OF COSMOS CLERK		47. SIGNATURE OF GALAXY CLERK		48. SIGNATURE OF UNIVERSE CLERK	
49. SIGNATURE OF COSMOS CLERK		50. SIGNATURE OF GALAXY CLERK		51. SIGNATURE OF UNIVERSE CLERK	
52. SIGNATURE OF COSMOS CLERK		53. SIGNATURE OF GALAXY CLERK		54. SIGNATURE OF UNIVERSE CLERK	
55. SIGNATURE OF COSMOS CLERK		56. SIGNATURE OF GALAXY CLERK		57. SIGNATURE OF UNIVERSE CLERK	
58. SIGNATURE OF COSMOS CLERK		59. SIGNATURE OF GALAXY CLERK		60. SIGNATURE OF UNIVERSE CLERK	
61. SIGNATURE OF COSMOS CLERK		62. SIGNATURE OF GALAXY CLERK		63. SIGNATURE OF UNIVERSE CLERK	
64. SIGNATURE OF COSMOS CLERK		65. SIGNATURE OF GALAXY CLERK		66. SIGNATURE OF UNIVERSE CLERK	
67. SIGNATURE OF COSMOS CLERK		68. SIGNATURE OF GALAXY CLERK		69. SIGNATURE OF UNIVERSE CLERK	
70. SIGNATURE OF COSMOS CLERK		71. SIGNATURE OF GALAXY CLERK		72. SIGNATURE OF UNIVERSE CLERK	
73. SIGNATURE OF COSMOS CLERK		74. SIGNATURE OF GALAXY CLERK		75. SIGNATURE OF UNIVERSE CLERK	
76. SIGNATURE OF COSMOS CLERK		77. SIGNATURE OF GALAXY CLERK		78. SIGNATURE OF UNIVERSE CLERK	
79. SIGNATURE OF COSMOS CLERK		80. SIGNATURE OF GALAXY CLERK		81. SIGNATURE OF UNIVERSE CLERK	
82. SIGNATURE OF COSMOS CLERK		83. SIGNATURE OF GALAXY CLERK		84. SIGNATURE OF UNIVERSE CLERK	
85. SIGNATURE OF COSMOS CLERK		86. SIGNATURE OF GALAXY CLERK		87. SIGNATURE OF UNIVERSE CLERK	
88. SIGNATURE OF COSMOS CLERK		89. SIGNATURE OF GALAXY CLERK		90. SIGNATURE OF UNIVERSE CLERK	
91. SIGNATURE OF COSMOS CLERK		92. SIGNATURE OF GALAXY CLERK		93. SIGNATURE OF UNIVERSE CLERK	
94. SIGNATURE OF COSMOS CLERK		95. SIGNATURE OF GALAXY CLERK		96. SIGNATURE OF UNIVERSE CLERK	
97. SIGNATURE OF COSMOS CLERK		98. SIGNATURE OF GALAXY CLERK		99. SIGNATURE OF UNIVERSE CLERK	
100. SIGNATURE OF COSMOS CLERK		101. SIGNATURE OF GALAXY CLERK		102. SIGNATURE OF UNIVERSE CLERK	

CERTIFICATE OF DEATH

04672

Reg. Dist. No.

4675

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4806 Rittenhouse Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale,	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4806 Rittenhouse Street		d. STREET ADDRESS 14806 Rittenhouse	
3. NAME OF DECEASED (Type or print) First MABEL Middle BELL Last JONES		4. DATE OF DEATH Month April Day 13th , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 10th, 1882
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Turner		14. MOTHER'S MAIDEN NAME Alice Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-34-4349B	
17. INFORMANT Willard E. Jones		Address 4806 Rittenhouse St. Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiac vascular DUE TO (c) renal disease			INTERVAL BETWEEN ONSET AND DEATH 3 days 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-10-59 19, to 4-13-59 19, that I last saw the deceased alive on 4-13-59 19, and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum		DATE SIGNED 4/13/1959	
PHYSICIAN'S NAME (Type) JOHN P. CLUM		ADDRESS 6110--43rd Ave., Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/16/1959	22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE APR 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and to any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4643 CERTIFICATE OF DEATH

04673
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 15x-2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington D.C. b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (16) d. STREET ADDRESS 5319 YORKTOWN Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dr. Thomas Glenn Jones		4. DATE OF DEATH Month Day Year April 28 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 7 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Physician	
11. BIRTHPLACE (State or foreign country) Washington DC.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Glenn Jones		14. MOTHER'S MAIDEN NAME Elizebeth King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 095-09-4451A	
17. INFORMANT Mr. Maureen Therese - Carroll		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-17 , 19 58 , to 4-28 , 19 59 , that I last saw the deceased alive on 4-27 , 19 59 , and that death occurred at 11:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 325 - H ST NE DATE SIGNED 4-28-59			
ACTUAL SIGNATURE Thomas F Collins M.D.			
PHYSICIAN'S NAME (Type) THOMAS F COLLINS WASH DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF May 1, 1959	22c. NAME OF CEMETERY OR CREMATORY Rock Creek	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE P. Saffell		24a. REC'D BY REGISTRAR DATE MAY 1 '59	
ADDRESS 475-H-NY Wash		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG241 4-27-59 et

CERTIFICATE OF DEATH

04674

Reg. Dist. No.

4676

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Takechiyo		4. DATE OF DEATH Month April Day 22 Year 19 59	
5. SEX Female	6. COLOR OR RACE Oreintal	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Japan	
11. BIRTHPLACE (State or foreign country) Japan		12. CITIZEN OF WHAT COUNTRY? Japan	
13. FATHER'S NAME ---Nobutada		14. MOTHER'S MAIDEN NAME unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John Katsu-4503-24th Ave. Avondale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, RT. MID. CEREBRAL ARTERY 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROSIS, CEREBRAL ARTERIES DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 1 YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1, 1958 to APRIL 22, 1959 , that I last saw the deceased alive on APRIL 22, 1959 , and that death occurred at 4:05A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel N Sugar		DATE SIGNED MT. RAINIER, Md. Apr 22 '59	
PHYSICIAN'S NAME (Type) Dr. Sam Sugar., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF April 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.A. Hines Co.		ADDRESS 2901-14th St. N.W. Wash. D.C.	
24a. REC'D BY REGISTRAR APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4721

CERTIFICATE OF DEATH

04675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON				c. LENGTH OF STAY IN 1b 5 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 3 Box 31				d. STREET ADDRESS 1 RT 3 Box 31			
3. NAME OF DECEASED (Type or print) AURA First LEONA Middle LAKEMAN Last				4. DATE OF DEATH APRIL 19 1959 Month 19 Day 19 Year 1959			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR 28, 1885 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10b. KIND OF BUSINESS OR INDUSTRY J.C. PENNEY		11. BIRTHPLACE (State or foreign country) NEW HAMPSHIRE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SETH QUINBY				14. MOTHER'S MAIDEN NAME AURA ANNEDOW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 001-01-686		17. INFORMANT LOUISE MARION ROSENTHAL Address RT 3 Box 31 CLINTON MD. DAUGHTER			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETIC-ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES 25 YRS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 PREVIOUS MYOCARDIAL INFARCTIONS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year None Hour None p.m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from SEPT 9, 1958 to PRESENT , that I last saw the deceased alive on MAR. 25, 1959 , and that death occurred at 5:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur Shaver Jr. M.D.				ADDRESS (Street, city or town, state) Branch Ave.-Clinton Md. DATE SIGNED Apr 19, 1959			
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.				ADDRESS BRANCH AVE.-CLINTON MD. DATE APR. 19, '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-59		22c. NAME OF CEMETERY OR CREMATORY Blossom Hill		22d. LOCATION (City, town, or county) (State) Concord New Hampshire	
23. FUNERAL DIRECTOR'S SIGNATURE Summons Bros. ADDRESS 1661- Good Hope Rd SE WASH. DC				24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

DECEASED NAME SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE PAY DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH TIME OF DEATH SIGNATURE OF DECEASED SIGNATURE OF WITNESSES SIGNATURE OF PHYSICIAN SIGNATURE OF CORONER SIGNATURE OF JURY SIGNATURE OF JUDGE SIGNATURE OF CLERK SIGNATURE OF REGISTRAR SIGNATURE OF SHERIFF SIGNATURE OF SORCERER SIGNATURE OF WITCH SIGNATURE OF ENCHANTER SIGNATURE OF FORTUNE TELLER SIGNATURE OF PALMIST SIGNATURE OF ASTROLOGER SIGNATURE OF ALMANAC SIGNATURE OF HOROSCOPE SIGNATURE OF EPHEMERIS SIGNATURE OF ALMANAC SIGNATURE OF HOROSCOPE SIGNATURE OF EPHEMERIS		COUNTY CITY TOWN VILLAGE DISTRICT PARISH CHURCH CONGREGATION SYNAGOGUE MOSQUE TEMPLE CHAPEL CHURCH CONGREGATION SYNAGOGUE MOSQUE TEMPLE CHAPEL
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W. H. C. COLLECTION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

FOR STATE
HEALTH DEPT

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7508 Hawthorne Street		d. STREET ADDRESS 7508 Hawthorne Street	
3. NAME OF DECEASED (Type or print) Margaret Ann Land		4. DATE OF DEATH Month April Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1959
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kenneth Alfred Land		14. MOTHER'S MAIDEN NAME Margaret Ann Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 3704 40th Avenue	
17. INFORMANT Thomas W. Scott; Cottage City, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 492X DUE TO underlying cause lost (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED April 7, 1959.	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/59	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE APR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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OFFICIAL USE ONLY

THIS IS A PRELIMINARY REPORT AND SHOULD NOT BE USED FOR STATISTICAL PURPOSES
OR FOR ANY OTHER PURPOSE WITHOUT THE APPROVAL OF THE STATE HEALTH DEPARTMENT
OR THE BUREAU OF VITAL STATISTICS

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John A. Johnson, Jr.	
Sex		Male	
Race		White	
Date of Birth		April 1, 1904	
Place of Birth		Baltimore, Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Date of Death		April 1, 1959	
Place of Death		Baltimore, Maryland	
Signature of Physician		[Signature]	
Date of Report		April 1, 1959	
Place of Report		Baltimore, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6241 5-1-59 et

CERTIFICATE OF DEATH

4677

04677

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CELANO MEMORIAL</u>		d. STREET ADDRESS <u>14704 Garret Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William P Lankford</u>		4. DATE OF DEATH <u>April 24 1959</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-21-96</u>
9. AGE (In years lost birth <u>62 1/2</u> yrs.)		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>WILLIAM LANKFORD</u>		14. MOTHER'S MAIDEN NAME <u>MAR LONE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WILLIAM LANKFORD - SON</u>		Address	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Coronary Atherosclerosis</u> (c) <u>Chronic Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 yrs</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>psilocyphoria</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/16</u> , 19 <u>58</u> , to <u>4/24/59</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>59</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J M Warren</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4/24/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Home</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home - De</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04678
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale, Hyattsville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale, Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2201 Beechwood Road			d. STREET ADDRESS 2201 Beechwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Frank William Lee			4. DATE OF DEATH Month April Day 13 Year 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1883		9. AGE (In years last day) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker		10b. KIND OF BUSINESS OR INDUSTRY City Bank Vice-President		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Francis Lee			14. MOTHER'S MAIDEN NAME Isabelle ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-10-2322		17. INFORMANT Records at City Bank, Wash.D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Cardiovascular renal disease					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 13, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/16/1959	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE APR 15 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12, 1950

DEATH CERTIFICATE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4678

04679
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b B.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4/ Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 31 Avondale Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Harry Harvey Gilmore Leishure			4. DATE OF DEATH Month April Day 14 Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-07		9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY State Roads		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Morris Leishure			14. MOTHER'S MAIDEN NAME Lottie Wells		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Goldie Leishure; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-59		22c. NAME OF CEMETERY OR CREMATORY Ivy Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgley Selby		ADDRESS 1200 Snowden Place, Laurel, Md.		24a. REC'D BY REGISTRAR DATE APR 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1955	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTH DATE		BIRTH PLACE	
JAN 15 1890		BALTIMORE, MD	
EDUCATION		MARRIAGE	
HIGH SCHOOL		MARRIED	
RELIGION		CAUSE OF DEATH	
METHODIST		HEART DISEASE	
PREVIOUS ILLNESS		TREATMENT	
NONE		NONE	
SIGNS AND SYMPTOMS		POST MORTEM	
NONE		NONE	
FINDINGS		REMARKS	
NONE		NONE	
SIGNATURE		DATE	
JAN 15 1955		JAN 15 1955	

4723

CERTIFICATE OF DEATH

04680
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE (District of Columbia) b. COUNTY 188			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 25, D. C.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 21			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Tina Lee Lemons				4. DATE OF DEATH Month Day Year April 17 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1958	9. AGE (In years lost birthday) yrs. 8	IF UNDER 1 YEAR Months Days 8 12	IF UNDER 24 HRS. Hours Min. 17 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul R. Lemons				14. MOTHER'S MAIDEN NAME Clarsie M Cooke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT 823rd Installation Squadron Father Homestead AFB, Florida			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meningitis DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH 6 Mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from April 17 , 19 59 , to April 17 , 19 59 , that I last saw the deceased alive on April 17 , 19 59 , and that death occurred at 7:12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF Hospital Andrews DATE SIGNED April 17, 1959							
ACTUAL SIGNATURE John A. Moore		M.D. USAF Hospital Andrews					
PHYSICIAN'S NAME (Type) JOHN A MOORE CAPT USAF (MC)		Andrews AFB., Washington 25, D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 4/20/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county)	(State) Ind.			
23. FUNERAL DIRECTOR'S SIGNATURE Phary Chase Funeral Home			24. REC'D BY REGISTRAR APR 23 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hearn			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkland Md Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKLAND.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Residence</u>		d. STREET ADDRESS <u>5504 PARKLAND COURT</u>	
3. NAME OF DECEASED (Type or print) <u>Helene F Lennon</u>		4. DATE OF DEATH <u>April 12 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26 1889 69</u>
9. AGE (In years last birthday) yrs. <u>69</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GUS W. FORSBERG</u>		14. MOTHER'S MAIDEN NAME <u>MARGAROT STEEP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John E. Lennon</u>		Address <u>1403 DAN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chol Gastric enteritis since Jan 1959</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>natural causes</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2, 1959</u> , to <u>April 12, 1959</u> , that I last saw the deceased alive on <u>April 10, 1959</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.		DATE SIGNED <u>5440 Silver Hill Rd SE</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u>		<u>Washington 28 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>4/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzers Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lee's Son</u>		ADDRESS <u>300-45th St DC</u>	
DATE <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1752



PLACE OF DEATH 1752		DECEASED'S NAME [Illegible]	
SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF JURY [Illegible]		SIGNATURE OF JUDGE [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF NOTARY [Illegible]	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH

1752

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04682

Reg. Dist. No.

4679

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood d. STREET ADDRESS 3705 Upshur Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Francis Last Mack 4. DATE OF DEATH Month April Day 13 Year 19 59				5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11-2-27 9. AGE (In years last birthday) 31 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician 10b. KIND OF BUSINESS OR INDUSTRY Electrical 11. BIRTHPLACE (State or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James F. Mack 14. MOTHER'S MAIDEN NAME Lida Marshall				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.2 16. SOCIAL SECURITY NO. 17. INFORMANT Barbara Yates; 4704 Eades St., Rockville, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Cerebral laceration Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of head (c) Gunshot wound of head (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound of head.					
20c. TIME OF INJURY Month, Day, Year 2-15-59 Hour 4-11- o. m. 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Brentwood, Pr. Geo. (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 13, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/59		22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) Tuckerton Co. (State) N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons 4739 Baltimore Ave. Hyattsville, Md.				24a. REC'D BY REGISTRAR APR 15 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John J. Smith		Male		45		White		April 12, 1909		Home	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
1234 Main St., Baltimore, Md.		Physician		Heart Disease		Natural		4:30 PM		J. H. Jones, M.D.	
Previous Illness		Medical History		Post-mortem Examination		Toxicology		Burial		Remarks	
None		Hypertension, Diabetes		None		None		Buried in St. Mary's Cemetery		None	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Witness	
J. H. Jones, M.D.		Wm. H. Smith		John D. Doe		John E. Roe		John F. Roe		John G. Roe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4680

CERTIFICATE OF DEATH

04683

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Catherine Matthews		4. DATE OF DEATH April 24 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/78
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William Robey		14. MOTHER'S MAIDEN NAME Blanch E. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elizabeth Brooke		Address Daughter Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus left. a.s. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic Ht disease. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on April 24 , 19 59 , and that death occurred at 8 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. D. Bauer		ADDRESS (Street, city or town, state) 2513 Burkholder Rd.	
PHYSICIAN'S NAME (Type) Dr. R. D. Bauer		DATE SIGNED 4/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR APR 27 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thayer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4681
CERTIFICATE OF DEATH

Reg. Dist. No.

04684

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 19H 40Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Francis B. McAuliffe				4. DATE OF DEATH Month Day Year April 26 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-93	9. AGE (In years last birthday) 66 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food & Drug Inspector U.S. Government		11. BIRTHPLACE (State or foreign country) Randolph, Mass.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food & Drug Inspector U.S. Government		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		10c. CITIZEN OF WHAT COUNTRY? U.S.		10d. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert J. McAuliffe				14. MOTHER'S MAIDEN NAME Margaret McRauhey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Agnes McAuliffe				17. ADDRESS Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 17 hr. 3 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Apr. 25, 1959, to Apr. 26, 1959, that I last saw the deceased alive on Apr. 26, 1959, and that death occurred at 5:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.D. BAKER, M.D.				ADDRESS (Street, city or town, state) Prince Georges General Hospital, Cheverly, Md.			
DATE SIGNED 4/27/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/29/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
22d. LOCATION (City, town, or county) Colmar Manor, Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc.				ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X.3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1316 Corcoran St., N. W.	
3. NAME OF DECEASED (Type or print) First Middle Last Perry C. Miller		4. DATE OF DEATH Month Day Year 4 5 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated, not legally	8. DATE OF BIRTH 10/12/1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Munsey Realtor Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse Miller		14. MOTHER'S MAIDEN NAME Rosetta Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 578-12-5396	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Bronchogenic carcinoma, right lung, with metastasis to both lungs, liver, & mediastinal lymph nodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 22 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; convulsive disorder, post-traumatic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/31/ 19 58, to 4/5/ 19 59, that I last saw the deceased alive on 4/4/ 19 59, and that death occurred at 1:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		DATE SIGNED 4/5/59	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale Hospital Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/9/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jaynes		24a. REC'D BY REGISTRAR DATE APR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4639

CERTIFICATE OF DEATH

04686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Br Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Ind</i> b. COUNTY <i>Br Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Pk</i>		c. LENGTH OF STAY IN 1b <i>14</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4610 Guilford Rd</i>		d. STREET ADDRESS <i>same</i>	
3. NAME OF DECEASED (Type or print) <i>MARY First AMELIA Middle MORRISON Last</i>		4. DATE OF DEATH Month <i>APR</i> Day <i>25</i> Year <i>1959</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7 DEC 1872</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Charles Wentz</i>		14. MOTHER'S MAIDEN NAME <i>Beningna Hohn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT Address <i>George W. Morrison 4610 Guilford Rd. College Pk, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Bilateral Pulmonary Congestion</i>			
DUE TO <i>420.0</i> (b) <i>Arterio-sclerotic Heart Disease</i>			
DUE TO <i>2 decompensation</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 35</i> , 19 <i>56</i> , to <i>Apr 25</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Apr 25</i> , 19 <i>59</i> , and that death occurred at <i>12:00 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. L. Etienne</i>		DATE SIGNED <i>4713-Berwyn Rd #2459</i>	
PHYSICIAN'S NAME (Type) <i>W. L. ETIENNE</i>		<i>College Park, Md.</i>	
22a. BURIAL-CREATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 27, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Port Deposit, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee A. Patterson & Sons</i>		ADDRESS <i>Perryville, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hahn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: JOHN A. BROWN</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1910-01-15</p>		<p>4. Date of death: 1960-01-15</p>	
<p>5. Place of birth: Boston, Mass.</p>		<p>6. Place of death: Boston, Mass.</p>	
<p>7. Cause of death: Heart failure</p>		<p>8. Immediate cause: Myocardial infarction</p>	
<p>9. Duration of illness: 2 weeks</p>		<p>10. Usual place of abode: Home</p>	
<p>11. Name of attending physician: Dr. J. A. Smith</p>		<p>12. Name of informant: John A. Brown</p>	
<p>13. Signature of physician: [Signature]</p>		<p>14. Signature of informant: [Signature]</p>	
<p>15. Date of completion: 1960-01-15</p>		<p>16. Name of registrar: John A. Brown</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4645

CERTIFICATE OF DEATH

04687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>				c. LENGTH OF STAY IN b. <u>4 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hyattsville Convalescent + Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia ALBERTINA Mulhearn</u>				4. DATE OF DEATH Month Day Year <u>April 23 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/15/1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Julius E. Juenemann</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Robert C. Beall - 6315 Seabrook Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular thrombosis</u> 260X DUE TO <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>yes</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1958</u> to <u>April 1959</u> , that I last saw the deceased alive on <u>April 20 1959</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold A. Lear</u> M.D.				ADDRESS (Street, city or town, state) <u>905 Sheridan St Hyattsville, Md.</u>		DATE SIGNED <u>4/23/59</u>	
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEAR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> <u>4739 Baltimore Ave. Hyattsville, Md.</u>				24a. REGD. BY REGISTRAR <u>APR 27 1959</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hama</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04688

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>Dead on arrival</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosaryville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's Hospital</u>				d. STREET/ADDRESS <u>Dower House Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Leonard Newman</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>October 13, 1884</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Henry Newman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ida Proctor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Joseph M. Newman, Clinton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>442X</u> IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. DATE OF REMOVAL (Specify) <u>4/9/59</u>				22b. NAME OF CEMETERY OR CREMATORY <u>Rosaryville Catholic</u>		22c. LOCATION (City, town, or county) (State) <u>Rosaryville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hone, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrush</u>	

FOR STATE
HEALTH DEPT.
M

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES M. SMITH		45		M		W		APR 10 1954		HOME	
RESIDENT OF		CITY		COUNTY		STATE		MARRIED		SINGLE	
BALTIMORE		BALTIMORE		BALTIMORE		MD		YES		NO	
EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		AUTOPSY	
HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		NONE		NO	
SIX MONTHS		FIVE YEARS		CORONARY THROMBOSIS		SUICIDE		NONE		NO	
NINE YEARS		TEN YEARS		MYOCARDIAL INFARCTION		ACCIDENT		NONE		NO	
ELEVEN YEARS		ELEVEN YEARS		CORONARY Atherosclerosis		HOMICIDE		NONE		NO	
TWELVE YEARS		TWELVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTEEN YEARS		THIRTEEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FOURTEEN YEARS		FOURTEEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTEEN YEARS		FIFTEEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTEEN YEARS		SIXTEEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTEEN YEARS		SEVENTEEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTEEN YEARS		EIGHTEEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETEEN YEARS		NINETEEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY YEARS		TWENTY YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY ONE YEARS		TWENTY ONE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY TWO YEARS		TWENTY TWO YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY THREE YEARS		TWENTY THREE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY FOUR YEARS		TWENTY FOUR YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY FIVE YEARS		TWENTY FIVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY SIX YEARS		TWENTY SIX YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY SEVEN YEARS		TWENTY SEVEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY EIGHT YEARS		TWENTY EIGHT YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
TWENTY NINE YEARS		TWENTY NINE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY YEARS		THIRTY YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY ONE YEARS		THIRTY ONE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY TWO YEARS		THIRTY TWO YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY THREE YEARS		THIRTY THREE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY FOUR YEARS		THIRTY FOUR YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY FIVE YEARS		THIRTY FIVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY SIX YEARS		THIRTY SIX YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY SEVEN YEARS		THIRTY SEVEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY EIGHT YEARS		THIRTY EIGHT YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
THIRTY NINE YEARS		THIRTY NINE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY YEARS		FORTY YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY ONE YEARS		FORTY ONE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY TWO YEARS		FORTY TWO YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY THREE YEARS		FORTY THREE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY FOUR YEARS		FORTY FOUR YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY FIVE YEARS		FORTY FIVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY SIX YEARS		FORTY SIX YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY SEVEN YEARS		FORTY SEVEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY EIGHT YEARS		FORTY EIGHT YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FORTY NINE YEARS		FORTY NINE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY YEARS		FIFTY YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY ONE YEARS		FIFTY ONE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY TWO YEARS		FIFTY TWO YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY THREE YEARS		FIFTY THREE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY FOUR YEARS		FIFTY FOUR YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY FIVE YEARS		FIFTY FIVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY SIX YEARS		FIFTY SIX YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY SEVEN YEARS		FIFTY SEVEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY EIGHT YEARS		FIFTY EIGHT YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
FIFTY NINE YEARS		FIFTY NINE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY YEARS		SIXTY YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY ONE YEARS		SIXTY ONE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY TWO YEARS		SIXTY TWO YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY THREE YEARS		SIXTY THREE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY FOUR YEARS		SIXTY FOUR YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY FIVE YEARS		SIXTY FIVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY SIX YEARS		SIXTY SIX YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY SEVEN YEARS		SIXTY SEVEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY EIGHT YEARS		SIXTY EIGHT YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SIXTY NINE YEARS		SIXTY NINE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY YEARS		SEVENTY YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY ONE YEARS		SEVENTY ONE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY TWO YEARS		SEVENTY TWO YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY THREE YEARS		SEVENTY THREE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY FOUR YEARS		SEVENTY FOUR YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY FIVE YEARS		SEVENTY FIVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY SIX YEARS		SEVENTY SIX YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY SEVEN YEARS		SEVENTY SEVEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY EIGHT YEARS		SEVENTY EIGHT YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
SEVENTY NINE YEARS		SEVENTY NINE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY YEARS		EIGHTY YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY ONE YEARS		EIGHTY ONE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY TWO YEARS		EIGHTY TWO YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY THREE YEARS		EIGHTY THREE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY FOUR YEARS		EIGHTY FOUR YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY FIVE YEARS		EIGHTY FIVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY SIX YEARS		EIGHTY SIX YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY SEVEN YEARS		EIGHTY SEVEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY EIGHT YEARS		EIGHTY EIGHT YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
EIGHTY NINE YEARS		EIGHTY NINE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY YEARS		NINETY YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY ONE YEARS		NINETY ONE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY TWO YEARS		NINETY TWO YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY THREE YEARS		NINETY THREE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY FOUR YEARS		NINETY FOUR YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY FIVE YEARS		NINETY FIVE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY SIX YEARS		NINETY SIX YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY SEVEN YEARS		NINETY SEVEN YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY EIGHT YEARS		NINETY EIGHT YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
NINETY NINE YEARS		NINETY NINE YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	
ONE HUNDRED YEARS		ONE HUNDRED YEARS		CORONARY Atherosclerosis		SUICIDE		NONE		NO	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, CITY OF BALTIMORE, AND TO THE COUNTY HEALTH DEPARTMENT, BALTIMORE COUNTY, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04689

Reg. Dist. No.

4683

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN 1b 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 5707 Longfellow St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amos A Norton		First Amos Middle A Last Norton		4. DATE OF DEATH April 27 19 59		Month April Day 27 Year 19 59	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-26-75	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James F. Norton				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 571-078412-4208-34		17. INFORMANT Edward C. Norton Address 7016 Greig St., Mt. Rainier, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct & mural thrombus 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ather. mas. ocd. & the last dec. branch l. p. an DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Much pulm. infarct left lung							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/9 1959 to 4/27 1959 , that I last saw the deceased alive on 4/27 1959 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Max M. Herzberg				ADDRESS (Street, city or town, state) DATE SIGNED 7016 GREIG ST., SEAT-PLEASANT, MD. 4/28/59			
PHYSICIAN'S NAME (Type) Dr. Max Herzberg							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Halleys Funeral Home, Mt. Rainier, Inc. Md.				24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

NAME: *John Doe*

DATE OF DEATH: *Jan 15 1922*

PLACE OF DEATH: *Home*

CAUSE OF DEATH: *Heart Disease*

LOCATION: *Baltimore, Md*

Signature: *[Signature]*

Vertical text on the right margin, likely a filing or archival note.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04690

Reg. Dist. No.

4684

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks	
c. LENGTH OF STAY IN b. 3 Month		d. STREET ADDRESS 5628 Addison Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John J. Perry		4. DATE OF DEATH Apr. 3 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1933
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Kitchen of Hosp.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Foster Perry		14. MOTHER'S MAIDEN NAME Lillie Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Brown, Aunt,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 223x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Angiothrombosis of cerebral vessels DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 7 , 19 59 , to Apr. 3 , 19 59 , that I last saw the deceased alive on Apr. 3 , 19 59 , and that death occurred at 8 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R.D. Baker M.D.		ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd. Adelphi Md.	
PHYSICIAN'S NAME (Type) R.D. BAKER, M.D.		DATE SIGNED 4/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-9-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) 4611-Berning rd N.E.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons		ADDRESS 467-7874	
24a. RECEIVED BY REGISTRAR APR 9 1959		DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. House		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BOND

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Jan 1, 1920		Male		White		Married		Teacher		Heart Disease		Home		Jan 15, 1950		4:30 PM		J. Smith		A. Jones	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Maryland		Jan 15, 1950		Male		White		Married		Teacher		Heart Disease		Home		Jan 15, 1950		4:30 PM		J. Smith		A. Jones	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Maryland		Jan 15, 1950		Male		White		Married		Teacher		Heart Disease		Home		Jan 15, 1950		4:30 PM		J. Smith		A. Jones	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT. NO FEE IS CHARGED FOR THIS CERTIFICATE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04691

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevery		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 9220 Defense Highway	
3. NAME OF DECEASED (Type or print) Margaret Catherine Peters		4. DATE OF DEATH Month April Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Aug 1884
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Samuel C. Peters, 9220 Defense Hwy. Lanham, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia infection 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/4 , 19 59 , to 4/27 , 19 59 , that I last saw the deceased alive on 4/26 , 19 59 , and that death occurred at 6:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) 4810 78th Ave	
PHYSICIAN'S NAME (Type) D. Fred. Misser., M.D.		DATE SIGNED 4/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/1959	
22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE APR 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

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TABLE 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4726

CERTIFICATE OF DEATH

Reg. Dist. No.

04692

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bradbury Heights</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bradbury Heights</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>12406 - 53rd Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>Connor</i> Last <i>Plott</i>				4. DATE OF DEATH Month <i>4</i> Day <i>4</i> Year <i>1959</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/25/1890</i>	
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Mechanic</i>		11. BIRTHPLACE (State or foreign country) <i>Mount Airy NC.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Rudolph Plott</i>		14. MOTHER'S MAIDEN NAME <i>Mary Davidson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes Army 1910-13</i>		16. SOCIAL SECURITY NO. <i>13-035-034-</i>		17. INFORMANT <i>Eva Sweeney</i>		Address <i>2406 - 53rd Ave. Bradbury Heights</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Acute Pulmonary Edema. Bilateral Hydrothorax.</i> DUE TO (b) <i>Myocardial Infarction. Occlusion of rt. coronary.</i> DUE TO (c) <i>Coronary Arteriosclerotic Heart Disease.</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours.</i> <i>years.</i>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>April 19, 1958</i> , to <i>4/4</i> , 1959, that I last saw the deceased alive on <i>4/4</i> , 1959, and that death occurred at <i>10:20</i> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Peter Daus</i> M.D.				ADDRESS (Street, city or town, state) <i>6124 Central Ave Capital Heights P.G. Md.</i>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>4-8-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl.</i>	
22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros</i> ADDRESS <i>1661 - Good Hope Rd SE Wash DC</i>				24a. REC'D BY REGISTRAR <i>APR 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04693
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Lanham		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1/2 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Lanham	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ruth Vassie Podesta			4. DATE OF DEATH Month April Day 9 Year 19 59		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-54 1900		9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Florida		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME William Carlos Stokes			14. MOTHER'S MAIDEN NAME Sarah Emma Hickman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Alma Uomini; Decatur Heights, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			DATE SIGNED April 9, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF April 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Brooklyn	
22d. LOCATION (City, town, or county) New York		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons			ADDRESS Hyattsville Md.		
24a. REC'D BY REGISTRAR DATE APR 13 '59			24b. REGISTRAR'S SIGNATURE Arthur L. Evans		

2

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John T. Tabor, M.D.		Male		45		April 2, 1920	
Place of Birth		Race		Color		Marital Status	
Baltimore, Md.		White		White		Married	
Usual Residence		Occupation		Education		Religion	
Baltimore, Md.		Physician		College		Roman Catholic	
Cause of Death		Manner of Death		Place of Death		Time of Death	
Myocardial Infarction		Natural		Home		10:30 AM	
History of Disease		Previous Illnesses		Injury or Violence		Alcohol or Drugs	
Hypertension		None		None		None	
Signs and Symptoms		Postmortem Findings		Toxicology		Other	
Chest pain, shortness of breath		Coronary artery disease		None		None	
Death certificate signed by		Physician		Medical Examiner		Other	
John T. Tabor, M.D.		John T. Tabor, M.D.		John T. Tabor, M.D.		John T. Tabor, M.D.	
Signature		Signature		Signature		Signature	
Date		Date		Date		Date	
April 2, 1920		April 2, 1920		April 2, 1920		April 2, 1920	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4687
CERTIFICATE OF DEATH

04694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. STREET ADDRESS <u>5453 Madison Way</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Clarence Elmer Polhamus</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>19 59</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1st, 1896</u>		9. AGE (In years lost birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (State or foreign country) <u>Modena, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Polhamus</u>		14. MOTHER'S MAIDEN NAME <u>Martha Schoemaker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>					
17. INFORMANT <u>Frances C. Polhamus, 5453 Madison Way, Hyattsville P.O., Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/9/1952</u> to <u>4/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>59</u> , and that death occurred at <u>8:35</u> A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>4410 54th Ave</u>		DATE SIGNED <u>4/17/59</u>		ACTUAL SIGNATURE <u>F. E. Musser</u>		M.D. <u>Fendover Hills, Md.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Pr. Geo. Co., Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		ADDRESS <u>5801 Cleveland Ave</u>		24a. REC'D BY REGISTRAR <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>		VS A15 (4) 15M 10/57											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1963

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	
John Doe		Male		White		1/1/1900		New York		123 Main St		1/15/1963		New York		Heart Disease		Natural		[Signature]		[Signature]	
13. Date of funeral		14. Name of funeral home		15. Name of cemetery		16. Name of minister		17. Name of undertaker		18. Name of embalmer		19. Name of mortician		20. Name of physician		21. Name of registrar		22. Name of coroner		23. Name of judge		24. Name of jury	
1/20/1963		Doe & Sons		Greenwood		Rev. Smith		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

THIS CERTIFICATE OF DEATH IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4646

CERTIFICATE OF DEATH

04695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	c. LENGTH OF STAY in 1b <u>5 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5029-37TH AVE.</u>		d. STREET ADDRESS <u>5029-37TH AVE.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Niki</u> Middle <u>PREZZI</u> Last <u>PREZZI</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-89</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOSEPH PREZZI</u>		14. MOTHER'S MAIDEN NAME <u>JUSTINA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-26-4232</u>	17. INFORMANT <u>VIRGIL PREZZI - 6914-23rd Pl. LEWISDALE MO.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 months</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 19, 1959</u> to <u>Sept 1, 1959</u> , that I last saw the deceased alive on <u>Nov 31, 1959</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Brady</u>		DATE SIGNED <u>35-114 Ave. NW</u>	
PHYSICIAN'S NAME (Type) <u>J. CHESTER BRADY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>4-4-59</u>	<u>FT. LINCOLN</u>	<u>BLADENSBURG, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>	
ADDRESS <u>-3831-GA. AVE. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04696
Reg. Dist. No.

4727

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>	
c. LENGTH OF STAY IN 1b <u>30 years</u>		d. STREET ADDRESS <u>5885 Allentown Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5885 Allentown Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rhody Orme Pyley</u>		4. DATE OF DEATH <u>April 15 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 9, 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Pyles</u>		14. MOTHER'S MAIDEN NAME <u>Dolly Tanley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>I</u>	
17. INFORMANT <u>Adelia G. Pyles, same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>April 15, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bells Meth. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Camp Springs Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		24a. REC'D BY REGISTRAR <u>1661 - Good Hope Rd SE WASH DC</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneale</u>		DATE <u>APR 17 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, mostly illegible handwritten text and markings are visible throughout the form, including what appears to be a signature and date in the lower right section.]

BOARD

4728

CERTIFICATE OF DEATH

04697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DIST. OF COLUMBIA</u> b. COUNTY <u>COLUMBIA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENN DALE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>GLENN DALE HOSP.</u>		d. STREET ADDRESS <u>33 FENTON PL. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>ROBINSON</u> Last <u>ROBINSON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/05</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR: Months <u>53</u> Days <u>18</u> Hours <u>19</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIN SETTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOWLING ALLEY</u>	
11. BIRTHPLACE (State or foreign country) <u>DIST. OF COLUMBIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>CHARLES ROBINSON</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE FOSTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-03-9617</u>	
17. INFORMANT <u>DECEASED</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY HEMORRHAGE</u> DUE TO <u>PULMONARY TUBERCULOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7 YRS. 10 MOS.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULM. FIBROSIS + EMPHYSEMA; COR PULMONALE</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/22</u> , 19 <u>55</u> , to <u>4/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/18</u> , 19 <u>59</u> , and that death occurred at <u>5:40</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>MOE WEISS</u>		ADDRESS (Street, city or town, state) <u>GLENN DALE HOSP.</u> DATE SIGNED <u>4/19/59</u>	
PHYSICIAN'S NAME (Type) <u>MOE WEISS, M.D.</u>		<u>GLENN DALE, MD.</u>	
22a. DATE OF REMOVAL (Specify)	22b. DATE THEREOF <u>4/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McP. McEntire</u>		24a. REC'D BY REGISTRAR <u>APR 21 '59</u>	
ADDRESS <u>424 Q St NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM EDWARD

Name of deceased		Age		Sex		Race		Color		Religion		Marital status		Occupation		Cause of death		Date of death		Place of death		Signature of physician		Signature of registrar		Signature of witness	
WILLIAM EDWARD		35		Male		White		White		Roman Catholic		Single		Carpenter		Heart disease		April 15, 1918		City of Portland		J. H. Smith		A. B. Jones		C. D. Brown	
Date of birth		Place of birth		Date of death		Place of death		Cause of death		Date of death		Place of death		Cause of death		Date of death		Place of death		Cause of death		Date of death		Place of death		Cause of death	
April 15, 1918		City of Portland		April 15, 1918		City of Portland		Heart disease		April 15, 1918		City of Portland		Heart disease		April 15, 1918		City of Portland		Heart disease		April 15, 1918		City of Portland		Heart disease	
Date of birth		Place of birth		Date of death		Place of death		Cause of death		Date of death		Place of death		Cause of death		Date of death		Place of death		Cause of death		Date of death		Place of death		Cause of death	
April 15, 1918		City of Portland		April 15, 1918		City of Portland		Heart disease		April 15, 1918		City of Portland		Heart disease		April 15, 1918		City of Portland		Heart disease		April 15, 1918		City of Portland		Heart disease	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4729

CERTIFICATE OF DEATH

04698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 year and 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 454 K. St., N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Noel Middle O. Last Roeser		4. DATE OF DEATH Month 4 Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/03
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd jobs	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Roeser		14. MOTHER'S MAIDEN NAME Fannie Wellington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1942 - 1945 579-12-2556	
17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 162.1 IMMEDIATE CAUSE (a) with metastasis to liver, bony skeleton, and lymph nodes. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis; right upper lobectomy, 1/22/59, for tuberculosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 4/16 , 19 58 , to 4/24 , 19 59 , that I last saw the deceased alive on 4/23 , 19 59 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Moe Weiss (M.D.) M.D. Glenn Dale Hospital 4/24/59 PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/28/59		22b. DATE THEREOF 4/28/59	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEM. FT. MYER VA.		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 1400 Chambers St. NW		24a. REC'D BY REGISTRAR DATE APR 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1880		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MARYLAND	
DATE OF DEATH		HOUR OF DEATH		TIME OF DAY		TEMPERATURE		PULSE	
JAN 20 1920		10:30 AM		10:30 AM		98.6		100	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1920		JAN 20 1920		JAN 20 1920		JAN 20 1920		JAN 20 1920	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04699
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Route # 3, Box 644	
3. NAME OF DECEASED (Type or print) First Thomas Middle Edward Last Rynn Sr.		4. DATE OF DEATH Month April Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 27/92
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Rynn		14. MOTHER'S MAIDEN NAME Mary Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-05-0459	
17. INFORMANT Virginia Marie Brookes		Address Rt# 3 Box 594 Clinton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED April 21, 1959	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-59	
22c. NAME OF CEMETERY OR CREMATORY St Johns		22d. LOCATION (City, town, or county) (State) Clinton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		24a. REC'D BY REGISTRAR DATE APR 23 '59	
ADDRESS 131-11 St		24b. REGISTRAR'S SIGNATURE Arthur L. House	

U.S. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4689

CERTIFICATE OF DEATH

04700

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b adm. 1-10-58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK 15-17-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM			d. STREET ADDRESS 7121 WILLOW AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CATHERINE Middle H. Last SAMUELS			4. DATE OF DEATH Month April Day 3 Year 19 59		
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-1861		9. AGE (In years last birthday) yrs. 97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORMER HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME DAVID HUGHES			14. MOTHER'S MAIDEN NAME ANN DAVIS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records Laurel Sanitarium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Apoplexy (334) DUE TO (b) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis					INTERVAL BETWEEN ONSET AND DEATH 3 days many years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 to April 3 , 19 59 that I last saw the deceased alive on April 3 , 19 59 , and that death occurred at 10:45 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Erika P. Kraemer M.D.			ADDRESS (Street, city or town, state) Laurel Sanitarium 4-3-59		
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER			State Laurel Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
				22d. LOCATION (City, town, or county) (State) Baltimore County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE G. Arthur Walters, 254 Carroll St. W. 105			24a. REC'D BY REGISTRAR DATE APR 6 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4647

CERTIFICATE OF DEATH

04701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Catholi Manor-		d. STREET ADDRESS Kennedy - Watter	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Sandoz		4. DATE OF DEATH Month Day Year April 12 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Norfolk, Va.	
11. BIRTHPLACE (State or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Dr. Thomas Bryson Ward		14. MOTHER'S MAIDEN NAME Julia Paul	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 579-16-4861	
17. INFORMANT Mrs. Nancy Weir		21 Heskith St. Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19___, to April 12, 1959 , that I last saw the deceased alive on April 12, 1959 , and that death occurred at 4:00 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. McMahon M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3000 Penn Ave. Wash. D.C.	
PHYSICIAN'S NAME (Type) Thomas T. McMahon M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-59	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L		22d. LOCATION (City, town, or county) (State) FORT MYER VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Sewler		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR APR 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneale	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04702

Reg. Dist. No.

4730

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
c. LENGTH OF STAY IN 1b <u>11 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland Avenue</u>		d. STREET ADDRESS <u>Maryland Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry Ludwig Seitz</u>		4. DATE OF DEATH <u>April 12 1959</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 30, 1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>William Seitz</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Fehr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>318-0583059</u>	
17. INFORMANT <u>Seitz M Seitz, Son of A</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 12, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>4/15/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>COLLIER MANOR RD 6001 CO, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS</u>		ADDRESS <u>517-1125 SE, WASH. DC.</u>	
24a. REC'D BY REGISTRAR <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in agreement within 72 hours after death.

ARKANSAS STATE DEPARTMENT OF HEALTH - BATTLEBORO 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

62-80



1. Name of deceased <i>John Doe</i>	
2. Sex <i>Male</i>	
3. Age <i>45</i>	
4. Date of death <i>Jan 15, 1962</i>	
5. Place of death <i>Home</i>	
6. Cause of death <i>Heart disease</i>	
7. Manner of death <i>Natural</i>	
8. Signature of medical examiner <i>Dr. J. Smith</i>	
9. Signature of coroner <i>Mr. J. Brown</i>	
10. Signature of registrar <i>Ms. J. Green</i>	
11. Signature of funeral director <i>Mr. J. White</i>	
12. Signature of next of kin <i>Mr. J. Black</i>	
13. Signature of physician <i>Dr. J. Grey</i>	
14. Signature of undertaker <i>Mr. J. Blue</i>	
15. Signature of cemetery <i>St. Mary's</i>	
16. Signature of burial place <i>St. Mary's</i>	
17. Signature of interment place <i>St. Mary's</i>	
18. Signature of final disposition <i>St. Mary's</i>	
19. Signature of final disposition <i>St. Mary's</i>	
20. Signature of final disposition <i>St. Mary's</i>	
21. Signature of final disposition <i>St. Mary's</i>	
22. Signature of final disposition <i>St. Mary's</i>	
23. Signature of final disposition <i>St. Mary's</i>	
24. Signature of final disposition <i>St. Mary's</i>	
25. Signature of final disposition <i>St. Mary's</i>	
26. Signature of final disposition <i>St. Mary's</i>	
27. Signature of final disposition <i>St. Mary's</i>	
28. Signature of final disposition <i>St. Mary's</i>	
29. Signature of final disposition <i>St. Mary's</i>	
30. Signature of final disposition <i>St. Mary's</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04704

4690

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Carrollton)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 5913 85th Place.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Darlene Middle Kay Last Shaklee		4. DATE OF DEATH Month April Day 2 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 March 1959
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME William Eugene Shaklee		14. MOTHER'S MAIDEN NAME Rose Marie Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiration Arrested 762.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 1/2 days DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 March , 19 59 to 2 April , 19 59 , that I last saw the deceased alive on 2 April , 19 59 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville	
PHYSICIAN'S NAME (Type) Dr. J. W. Perkins, M.D.		DATE SIGNED 4/2/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/59	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2077364XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar and director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1930

SEE ON REVERSE

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1885</u></p>	
<p>5. Place of birth: <u>City of Baltimore, Md.</u></p>		<p>6. Usual residence: <u>123 Main St., Baltimore, Md.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Date of death: <u>Dec 10, 1930</u></p>	
<p>9. Time of death: <u>10:30 AM</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>12. Signature of registrar: <u>John Doe</u></p>	
<p>13. Signature of informant: <u>John Doe</u></p>		<p>14. Signature of witness: <u>John Doe</u></p>	
<p>15. Signature of undertaker: <u>John Doe</u></p>		<p>16. Signature of funeral home: <u>John Doe</u></p>	
<p>17. Signature of cemetery: <u>John Doe</u></p>		<p>18. Signature of burial place: <u>John Doe</u></p>	
<p>19. Signature of interment: <u>John Doe</u></p>		<p>20. Signature of final disposition: <u>John Doe</u></p>	

THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, HAS RECEIVED THE ABOVE CERTIFICATE OF DEATH, AND THE SAME IS HEREBY FILED FOR THE PURPOSES OF THE MARYLAND VITAL RECORDS ACT, AND THE DEATH OF THE DECEASED IS HEREBY CERTIFIED.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4731

CERTIFICATE OF DEATH

04705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 65th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Leonie M. Shepherd		4. DATE OF DEATH Month Day Year April 24, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1902
9. AGE (In years lost birthday) yrs. 56		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Scotland	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nul Grant		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Flora N. Harpine		Address 302 65th St. Md. Park	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10" 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction - 3rd row		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15 , 19 59 , to Present , 19 59 , that I last saw the deceased alive on 4/23 , 19 59 , and that death occurred at 2 PM 4/24/59 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4400 ROUTE 1, S.E. D.C. DATE SIGNED			
ACTUAL SIGNATURE Thomas F. Cobb M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		24a. REC'D BY REGISTRAR MAY 1 '59	
ADDRESS 4812 Ga. Ave. N.W. D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. PLACE OF DEATH BALTIMORE, MARYLAND	
3. SEX Male		4. AGE 45	
5. DATE OF DEATH April 1, 1948		6. TIME OF DEATH 10:30 AM	
7. CAUSE OF DEATH Myocardial Infarction		8. PLACE OF BIRTH BALTIMORE, MARYLAND	
9. OCCUPATION Salesman		10. MARITAL STATUS Married	
11. EDUCATION High School		12. RELIGION Roman Catholic	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None	
15. SIGNATURE OF PHYSICIAN J. H. HARRIS		16. SIGNATURE OF WITNESSES J. H. HARRIS	
17. SIGNATURE OF REGISTRAR J. H. HARRIS		18. SIGNATURE OF CLERK J. H. HARRIS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4691

CERTIFICATE OF DEATH

04706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 43 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1 2017 Patterson Street			
3. NAME OF DECEASED (Type or print) James First O Middle Short Last				4. DATE OF DEATH April Month 3 Day 19 Year 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Feb 1881		9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Steamfitter		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Short				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 577-05-3854		17. INFORMANT Address Helen Y. Hill, 4004--92nd St., Landover, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X DUE TO Suppurative embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia + bronchopneumonia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1 , 19 48 , to 4-2 , 19 59 , that I last saw the deceased alive on 4-3 , 19 59 , and that death occurred at 5:55 AM , from the causes and on the date stated above. ACTUAL SIGNATURE [Signature] M.D. [Signature] ADDRESS (Street, city or town, state) [Signature] DATE SIGNED 4-3-59 PHYSICIAN'S NAME (Type) Dr. A. Deitz, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Road, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Name of Deceased [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Usual Residence [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Place of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Signature [Illegible]		Date of Signature [Illegible]	

4692

CERTIFICATE OF DEATH

04707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES First R Middle SHULTZ Last		4. DATE OF DEATH APRIL Month 7 Day 1959 Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 11, 1876
9. AGE (in years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Funeral Director	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George R Shultz		14. MOTHER'S MAIDEN NAME Laura Hendrix	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Florence D Shultz		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Edema 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Gastro-enteritis DUE TO (c) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4 APRIL, 1959 to APRIL 6, 1959 , that I last saw the deceased alive on APRIL 6, 1959 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. Etienne		ADDRESS (Street, city or town, state) 4713 BERWYN RD College Park, Md	
PHYSICIAN'S NAME (Type) W. C. ETIENNE		DATE SIGNED 4-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation	22b. DATE THEREOF 4/8/59	22c. NAME OF CEMETERY OR CREMATORY Brazil	22d. LOCATION (City, town, or county) (State) Indiana
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR APR 10 1959		24b. REGISTRAR'S SIGNATURE W. C. Etienne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4732

CERTIFICATE OF DEATH

04708

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.H.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle A Last SMITH				4. DATE OF DEATH Month April Day 29 Year 19 59			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Aug 1917	9. AGE (In years lost birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY House wife		11. BIRTHPLACE (State or foreign country) Toledo, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry P. Fuhrer				14. MOTHER'S MAIDEN NAME Adelyne Last name unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Husband Chauncey W. Smith			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Gastrointestinal Hemorrhage 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Esophageal Varices DUE TO (c) Cirrhosis of the Liver						INTERVAL BETWEEN ONSET AND DEATH 15 Hrs. 3 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 29 Apr , 19 59 , to 29 Apr , 19 59 , that I last saw the deceased alive on 29 Apr , 19 59 , and that death occurred at 7:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF Hospital Andrews DATE SIGNED 29 Apr 59							
ACTUAL SIGNATURE William S. Vaun		M.D. USAF Hospital Andrews					
PHYSICIAN'S NAME (Type) WILLIAM S VAUN, CAPT, USAF (MC)		Andrews AFB Washington 25, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Rem	22b. DATE THEREOF 5-1-59	22c. NAME OF CEMETERY OR CREMATORY Fernwood Cemetery	22d. LOCATION (City, town, or county) (State) Henderson Kentucky				
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Lewis				ADDRESS 1736 Pa. Ave. N.W.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4733

CERTIFICATE OF DEATH

04709
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale				c. LENGTH OF STAY IN 1b X Avondale			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4807 Russell Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sylvester MacPhillan Smith				4. DATE OF DEATH Month Day Year April 26, 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Fruit Growers Express		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles A. Smith				14. MOTHER'S MAIDEN NAME Elizabeth B. Broomall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Amanda Smith-4807 Russell Avenue Avondale, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Heart Disease DUE TO (c) 1-2 yrs.							INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Hyattsville, Md.		(County) (State)	
21. I certify that I attended the deceased from Dec , 19 57 , to April 26 , 19 59 , that I last saw the deceased alive on April 2 , 19 59 , and that death occurred at 11:39 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert B. Ireay M.D. 7105 Riggs Rd. PHYSICIAN'S NAME (Type) Robert B. Ireay							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges Co., Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4693

CERTIFICATE OF DEATH

04710

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 3110 Upshur St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Warren Middle E. Last Smith		4. DATE OF DEATH Month April Day 11 Year 19 59		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 19/1874		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Book Binder		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Zopher Smith				14. MOTHER'S MAIDEN NAME Ann MacCauley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth H Wife		Address Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic heart disease DUE TO (c) 20 yrs INTERVAL BETWEEN ONSET AND DEATH 12h						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-10-59 , 19, to 4-11-59 , 19, that I last saw the deceased alive on April 11 , 19 59 , and that death occurred at 4:20A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John P. Clum M.D.				ADDRESS (Street, city or town, state) 4110 43rd Ave		DATE SIGNED 4-11-59	
PHYSICIAN'S NAME (Type) Dr. Clum				Hopkins			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/59		22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 13 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. H.			

CERTIFICATE OF DEATH

PART OF DEATH NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 68	
RACE White		BIRTH DATE 1871		BIRTH PLACE Baltimore, Md.	
OCCUPATION Retired		MARITAL STATUS Married		DATE OF DEATH 1941	
PLACE OF DEATH Home		CAUSE OF DEATH Heart Failure		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)		SIGNATURE OF PHYSICIAN (Signature)	
SIGNATURE OF CLERK (Signature)		SIGNATURE OF REGISTRAR (Signature)		SIGNATURE OF JUDGE (Signature)	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

4694

CERTIFICATE OF DEATH

04711
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>339 Laurel Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ida</i> Middle <i>W. Spruiggate</i> Last <i></i>		4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 26 1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Grayson Co. Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Wilkerson</i>		14. MOTHER'S MAIDEN NAME <i>Kitty Esbridge</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs Catherine DeBare</i>		Address <i>339 Laurel Ave Laurel, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension & Hypertension Heart Change</i> DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour <i></i> o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>4/29</i> , 19 <i>59</i> , to <i>4/29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4/29</i> , 19 <i>59</i> , and that death occurred at <i>10p</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W B Stewart</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>314 Compton 4/30/59</i>	
PHYSICIAN'S NAME (Type) <i>W B Stewart</i>		<i>Laurel Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 4, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Louisville Kentucky</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Donaldson</i>		ADDRESS <i>Laurel, Md</i>	
24a. REC'D BY REGISTRAR <i>MAY 4 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. PLACE OF DEATH</p>	
<p>7. OCCUPATION</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. TIME OF DEATH</p>		<p>14. PLACE OF INTERMENT</p>	
<p>15. NAME OF INTERMENT PLACE</p>		<p>16. NAME OF MINISTER</p>	
<p>17. NAME OF FUNERAL HOME</p>		<p>18. NAME OF CARRIER</p>	
<p>19. NAME OF BURIAL PLACE</p>		<p>20. NAME OF CEMETERY</p>	
<p>21. NAME OF CHURCH</p>		<p>22. NAME OF PASTOR</p>	
<p>23. NAME OF SPOUSE</p>		<p>24. NAME OF CHILDREN</p>	
<p>25. NAME OF SIBLINGS</p>		<p>26. NAME OF PARENTS</p>	
<p>27. NAME OF GRANDPARENTS</p>		<p>28. NAME OF AUNT/UNCLES</p>	
<p>29. NAME OF NEPHEWS/NIECES</p>		<p>30. NAME OF OTHER RELATIVES</p>	
<p>31. NAME OF FRIENDS</p>		<p>32. NAME OF OTHER PERSONS</p>	
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THE FOLLOWING INFORMATION IS FOR THE USE OF THE REGISTRAR OF DEATHS AND SHALL BE FURNISHED TO HIM BY THE PHYSICIAN, FUNERAL HOME, OR OTHER PERSON IN CHARGE OF THE DECEASED.

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. PLACE OF DEATH
7. OCCUPATION
8. CAUSE OF DEATH
9. MANNER OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR
12. DATE OF DEATH
13. TIME OF DEATH
14. PLACE OF INTERMENT
15. NAME OF INTERMENT PLACE
16. NAME OF MINISTER
17. NAME OF FUNERAL HOME
18. NAME OF CARRIER
19. NAME OF BURIAL PLACE
20. NAME OF CEMETERY
21. NAME OF CHURCH
22. NAME OF PASTOR
23. NAME OF SPOUSE
24. NAME OF CHILDREN
25. NAME OF SIBLINGS
26. NAME OF PARENTS
27. NAME OF GRANDPARENTS
28. NAME OF AUNT/UNCLES
29. NAME OF NEPHEWS/NIECES
30. NAME OF OTHER RELATIVES
31. NAME OF FRIENDS
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100. NAME OF OTHER PERSONS

4695

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Rt. 2 Box 87		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lula Sweeney				4. DATE OF DEATH Month Day Year April 13 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 June 1906	
9. AGE (In years last birthday) 52 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tenent		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Robert Sweeney (Rt. #2, Box 87, Upper Marlboro, Maryland)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Advanced metastatic carcinoma 3 mths? (c) Primary carcinoma of colon (splenic flexure) 1 year-3? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-9-1959, to 4-12-1959, that I last saw the deceased alive on 4-12-1959, and that death occurred at 4:35 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George H. McLain M.D. 1746 K St. N.W. Wash - D.C. 4/13/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. George McLain, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/59		22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE APR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AMERICAN BOND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
AGE		SEX	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4734

CERTIFICATE OF DEATH

04713

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Richmond			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 4 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS Warsaw 83X-3			
3. NAME OF DECEASED (Type or print) JOSIE - FRANCE TALLENT				4. DATE OF DEATH Month April Day 13 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1884	9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph France				14. MOTHER'S MAIDEN NAME Lenica Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wilbur McPherson-3900 75th.Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular Renal Disease DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 19 58 , to April 13 , 19 59 , that I last saw the deceased alive on April 11 , 19 59 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard Katzen M.D. 3550 - M. Ave. Wash. D.C.				DATE SIGNED 4-13-59			
PHYSICIAN'S NAME (Type) BERNARD KATZEN M.D. - 3550 - M. Ave. Wash. D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-59		22c. NAME OF CEMETERY OR CREMATORY Menokin Baptist Cem		22d. LOCATION (City, town, or county) (State) Ethel, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. 317 Pa. Ave., SE DC3				24a. REC'D BY REGISTRAR DATE APR 14 '59		24b. REGISTRAR'S SIGNATURE Civilian S. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04714

Reg. Dist. No.

4696

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 8915 Hickory Hill Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) William Andrew Terry			4. DATE OF DEATH Month April Day 5 Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1902		9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical engineer		10b. KIND OF BUSINESS OR INDUSTRY Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Terry			14. MOTHER'S MAIDEN NAME Mary Elizabeth Achemir		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) yes W.W.2		16. SOCIAL SECURITY NO.		17. INFORMANT William A. Terry; 3rd Address 506 Whitfield Chapel Road Lanham, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 6, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/8/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hattsville, Md.		24a. REC'D BY REGISTRAR APR 8 '59 DATE	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. H...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John F. Salomey, Jr.		AGE 35		SEX Male		RACE White	
DATE OF DEATH April 2, 1933		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION None		EDUCATION High School		RELIGION Catholic		MARRIAGE Married	
MARITAL STATUS Widow		PREVIOUS ILLNESS None		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER [Signature]		DATE April 2, 1933		PLACE Baltimore		COUNTY Baltimore	
SIGNATURE OF WITNESS [Signature]		DATE April 2, 1933		PLACE Baltimore		COUNTY Baltimore	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04715
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 10 min	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		d. STREET ADDRESS 10640 Odell Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Selma Memorial Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth Elwood Thornton		4. DATE OF DEATH April 8 1959	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-59
9. AGE (In years last birthday) yrs. 24		10. IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Elwood Thornton		14. MOTHER'S MAIDEN NAME Grace Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Father		Address Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 492X Congestive heart failure DUE TO (b) Pneumonitis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John D. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/59	
22c. NAME OF CEMETERY OR CREMATORY Round Oak		22d. LOCATION (City, town, or county) (State) Spencerville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE APR 13 '59			

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1/2 hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's		d. STREET ADDRESS Rt. # 2 Box 108 48X-3	
3. NAME OF DECEASED (Type or print) Charles Love Scott Tingley		4. DATE OF DEATH April 29, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1901
9. AGE (In years, months, days) 57 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles Tingley Sr.		14. MOTHER'S MAIDEN NAME Anna Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT Helen Shipley		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> collision			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Occupant of an automobile that was in an head on /	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:50xxx 4/ 29 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301		20f. (City or town) Upper Marlboro P. B. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 29, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/59	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) Philadelpha (State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ALL THINGS

1. Name of deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Cause of death: _____

5. Age of deceased: _____

6. Sex of deceased: _____

7. Occupation of deceased: _____

8. Marital status: _____

9. Name of physician: _____

10. Name of medical examiner: _____

11. Signature of physician: _____

12. Signature of medical examiner: _____

13. Date of examination: _____

14. Place of examination: _____

15. Name of hospital: _____

16. Name of doctor: _____

17. Name of nurse: _____

18. Name of attendant: _____

19. Name of undertaker: _____

20. Name of funeral home: _____

21. Name of cemetery: _____

22. Name of burial place: _____

23. Name of interment: _____

24. Name of monument: _____

25. Name of grave: _____

26. Name of lot: _____

27. Name of section: _____

28. Name of row: _____

29. Name of column: _____

30. Name of plot: _____

31. Name of monument: _____

32. Name of grave: _____

33. Name of lot: _____

34. Name of section: _____

35. Name of row: _____

36. Name of column: _____

37. Name of plot: _____

38. Name of monument: _____

39. Name of grave: _____

40. Name of lot: _____

41. Name of section: _____

42. Name of row: _____

43. Name of column: _____

44. Name of plot: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4699

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04717

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hospital</u>		d. STREET ADDRESS <u>Box 443 Route #2</u>	
4. NAME OF DECEASED (Type or print) <u>Tennessee Anna Toliver</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 23, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A</u>	
13. FATHER'S NAME <u>Benjamin Gosley</u>		14. MOTHER'S MAIDEN NAME <u>Fairbe Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>7-11-11-11-11</u>	
17. INFORMANT <u>Lettie Speller, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Acute Congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James H. Ford</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES L. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/8/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Lyons Co. 1300-N. Street Wash. D.C. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>		DATE SIGNED <u>April 5, 1959</u>	

1. NAME OF DECEASED: John Doe

2. SEX: Male

3. AGE: 45

4. OCCUPATION: Teacher

5. PLACE OF BIRTH: John Doe

6. DATE OF BIRTH: 1910

7. PLACE OF DEATH: John Doe

8. DATE OF DEATH: 1950

9. TIME OF DEATH: 10:00 AM

10. CAUSE OF DEATH: Heart Disease

11. MANNER OF DEATH: Natural

12. SIGNATURE OF EXAMINER: John Doe

13. SIGNATURE OF WITNESS: John Doe

14. SIGNATURE OF CORONER: John Doe

15. SIGNATURE OF JURY: John Doe

16. SIGNATURE OF JUDGE: John Doe

17. SIGNATURE OF CLERK: John Doe

18. SIGNATURE OF NURSE: John Doe

19. SIGNATURE OF PHYSICIAN: John Doe

20. SIGNATURE OF CHURCH: John Doe

21. SIGNATURE OF FUNERAL HOME: John Doe

22. SIGNATURE OF BURIAL: John Doe

23. SIGNATURE OF CREMATION: John Doe

24. SIGNATURE OF OTHER: John Doe

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04718

4700

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 41 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 6001 Pontiac St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha Elizabeth Townsend		First Middle Last		4. DATE OF DEATH April 13 19 59		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1901		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Leeds				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. E. Townsend Jr. 5402 Spring Lane, Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gt. Hemorrhage 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Gastric Ulcer DUE TO (c) Stress						INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4-59 , 19 59 , to 4-13-59 , 19 59 , that I last saw the deceased alive on 4-13-59 , and that death occurred at 2:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William C. Weintraut		M.D.		ADDRESS (Street, city or town, state) 3000 Rte 66, Hyattsville, Md.		DATE SIGNED 4-13-59	
PHYSICIAN'S NAME (Type) William C. Weintraut							
22a. BURIAL, CREMATION, REMOVAL (specify) Burial		22b. DATE THEREOF 4/15/59		22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE APR 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Place of Birth	
John J. Jones		45		Male		White		Jan 15, 1875		New York City	
Cause of Death		Duration of Illness		Place of Death		Date of Death		Time of Death		Signature of Physician	
Heart Disease		10 Days		Home		Jan 20, 1920		5:00 PM		J. H. Smith, M.D.	
Occupation		Education		Marital Status		Previous Illnesses		Signature of Informant		Date of Report	
Carpenter		High School		Married		None		W. J. Brown		Jan 22, 1920	
Signature of Informant		Relationship to Deceased		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
W. J. Brown		Son		J. H. Smith, M.D.		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE PUBLIC HEALTH SERVICE, AND IS NOT VALID FOR ANY OTHER PURPOSE.

RECEIVED

STATE DEPARTMENT OF HEALTH - BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4701 CERTIFICATE OF DEATH

04719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Heverly		c. LENGTH OF STAY IN 1b 43 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Octava Van Duzer		4. DATE OF DEATH April 19 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/1901
9. AGE (In years last birthday) 38 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Dury, Md.	
11. BIRTHPLACE (State or foreign country) United States		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Daniel Walker		14. MOTHER'S MAIDEN NAME Ellen Edelin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 577-48-9336	
17. INFORMANT Jacob Husband		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary-Arterio Sclerotic Heart Disease (c) Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 19 59, to April 19, 19 59, that I last saw the deceased alive on April 19, 19 59, and that death occurred at 6:20 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R.D. Bauer M.D.		ADDRESS (Street, city or town, state) Prince Georges General Hospital 1/19/59	
PHYSICIAN'S NAME (Type) R.D. Bauer M.D.		DATE SIGNED 1/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/59	
22c. NAME OF CEMETERY OR CREMATORY Addison Chapel		22d. LOCATION (City, town, or county) (State) Seat Pleasant, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 5801 Cleveland Ave.	
24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House	

— — — — —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4648

CERTIFICATE OF DEATH

Reg. Dist. No. 04720

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 38 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescent & Rest Home				d. STREET ADDRESS 14301-28 PL.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Peter Middle Francis Last Ward				4. DATE OF DEATH Month April Day 25 Year 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 3, 1883	
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney, Retired		11. BIRTH PLACE (State or foreign country) Nebraska	
13. FATHER'S NAME Charles Ward		14. MOTHER'S MAIDEN NAME Mary McGraime		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Peter Ward		Address 4301-28 PL.		18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 31 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 3/19, 1959, to 4/25, 1959, that I last saw the deceased alive on 4/25, 1959, and that death occurred at 2:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Albert Roth M.D.		Physician's NAME (Type) ALBERT ROTH		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE APR 29 '59	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE		24e. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04721
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 33 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4109 51st Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula Williamson				4. DATE OF DEATH April 21, 1959			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-13-75		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Alma Armstead, same address as # 2. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 970.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) Overdose of sedative (Doriden) (c) Overdose of sedative (Doriden) DUE TO (c) Overdose of sedative (Doriden)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was said to have consumed a large quantity of Doriden.					
20c. TIME OF INJURY Month, Day, Year 4-19-59 Hour 4:00 P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Bladensburg (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 22, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/59		22c. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS HYATTSTVILLE, MARYLAND		24a. REC'D BY REGISTRAR APR 24 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

64. FRONTIER-HEALTH TO ENHANCED STATE CHAIRMAN

[illegible]

CERTIFICATE OF DEATH

04722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louis James Wines		4. DATE OF DEATH Month Day Year April 9 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1895
9. AGE (In years lost birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Govt. Guard	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clinton Wines		14. MOTHER'S MAIDEN NAME Mary Elizabeth Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Wife-and Medical Record	
17. INFORMANT Wife-and Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior-arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 28, 1958 to 4-9, 1959 , that I last saw the deceased alive on 4-9, 1959 , and that death occurred at A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. Donald R. Purdie M.D.		22. PHYSICIAN'S NAME (Type) Dr. Donald R. Purdie	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/59	
22c. NAME OF CEMETERY OR CREMATORY East Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Colman Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Randolph, Laurel, Md		24a. REC'D BY REGISTRAR DATE APR 14 '59	
24b. REGISTRAR'S SIGNATURE Cyril L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED James Joseph		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF BIRTH May 10, 1892		6. PLACE OF BIRTH Harrisburg, Pa.	
7. DATE OF DEATH May 10, 1937		8. PLACE OF DEATH Harrisburg, Pa.	
9. TIME OF DEATH 10:00 AM		10. CAUSE OF DEATH Heart failure	
11. DISEASE OR INJURY Coronary artery disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN Dr. Donald A. Smith		14. SIGNATURE OF REGISTRAR [Signature]	
15. ADDRESS OF DECEASED [Address]		16. ADDRESS OF PHYSICIAN [Address]	
17. ADDRESS OF REGISTRAR [Address]		18. ADDRESS OF FUNERAL HOME [Address]	
19. ADDRESS OF NEXT OF KIN [Address]		20. ADDRESS OF BURIAL PLACE [Address]	



1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. DATE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. CAUSE OF DEATH
11. DISEASE OR INJURY
12. MANNER OF DEATH
13. SIGNATURE OF PHYSICIAN
14. SIGNATURE OF REGISTRAR
15. ADDRESS OF DECEASED
16. ADDRESS OF PHYSICIAN
17. ADDRESS OF REGISTRAR
18. ADDRESS OF FUNERAL HOME
19. ADDRESS OF NEXT OF KIN
20. ADDRESS OF BURIAL PLACE

05952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George c. HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS Route 1 Box 198 (See birth cert) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl A Williams				4. DATE OF DEATH Month April Day 14 Year 1959	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH April 14 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Newborn		9. AGE (In years last birthday) yrs. 4 IF UNDER 1 YEAR Months Days Hrs. Min. IF UNDER 24 HRS.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Guy Willaims				14. MOTHER'S MAIDEN NAME Joyce Mae Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mother, Joyce Mae Williams, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 776X DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 402 Main St.	
		20f. (City or town) Laurel, Md.		20g. (County) (State)	
21. I certify that I attended the deceased from Apr. 14 , 19 59 , to Apr. 14 , 19 59 , that I last saw the deceased alive on Apr. 14, 1959 , and that death occurred at 9:15 A. M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE John R. Buell		M.D. John R. Buell, M.D.		DATE SIGNED Apr. 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/4/59		22b. DATE THEREOF 5/4/59		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr		ADDRESS Administrators		24a. REC'D BY REGISTRAR MAY 8 '59	
				24b. REGISTRAR'S SIGNATURE Carlina S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS AIS (4)
15M 9/55

1100/171xV 0

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

00355

1703

NAME OF DECEASED JAMES EARL RAY		SEX Male		DATE OF BIRTH 5/3/28		PLACE OF BIRTH MOBILE, ALA.	
MARRIAGE Single		OCCUPATION Author		EDUCATION High School		RELIGION Methodist	
DECEASED AT HOME Yes		DECEASED AT PLACE OF BIRTH No		DECEASED AT PLACE OF RESIDENCE Yes		DECEASED AT PLACE OF WORK No	
DATE OF DEATH 4/4/68		TIME OF DEATH 10:00 AM		PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		IMMEDIATE CAUSE OF DEATH Myocardial Infarction		UNDERLYING CAUSE OF DEATH Coronary Artery Disease	
DECEASED AT HOME Yes		DECEASED AT PLACE OF BIRTH No		DECEASED AT PLACE OF RESIDENCE Yes		DECEASED AT PLACE OF WORK No	
DATE OF DEATH 4/4/68		TIME OF DEATH 10:00 AM		PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		IMMEDIATE CAUSE OF DEATH Myocardial Infarction		UNDERLYING CAUSE OF DEATH Coronary Artery Disease	

REGISTERED

TO BE FILLED BY THE REGISTRAR OF DEATHS
TO BE FILLED BY THE REGISTRAR OF DEATHS
TO BE FILLED BY THE REGISTRAR OF DEATHS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4704

CERTIFICATE OF DEATH

05953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George HOWARD ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS Route 1 Box 198 (See birth cert)	
3. NAME OF DECEASED (Type or print) First Baby B. Middle Girl Last Williams		4. DATE OF DEATH Month April Day 14 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1959
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours Min 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Guy Williams		14. MOTHER'S MAIDEN NAME Joyce Mae Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mother, Joyce Mae Williams, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 14, 1959, to Apr. 14, 1959, that I last saw the deceased alive on Apr. 14, 1959, and that death occurred at 9:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Apr. 15/59			
ACTUAL SIGNATURE John R. Buell, M.D.		M.D. 402 Main Street, Laurel, Md.	
PHYSICIAN'S NAME (Type) John R. Buell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 5/4/59	22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr Administrator.		24a. REC'D BY REGISTRAR DATE MAY 8 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

1200172XV0

4735

CERTIFICATE OF DEATH

04723
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park avenue				d. STREET ADDRESS Park Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nannie Middle CATHERINE Last Woods				4. DATE OF DEATH Month April Day 5 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 16, 1884	
9. AGE (In years last birthday) 74 years		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Samuel Spangler				14. MOTHER'S MAIDEN NAME Catherine Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles Woods		Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old left hemiplegia - 1950							
INTERVAL BETWEEN ONSET AND DEATH minutes year year							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Jan , 19 52 to April 5 , 19 59 , that I last saw the deceased alive on April 4 , 19 59 , and that death occurred at 4:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bowie Md DATE SIGNED 4/5/59							
ACTUAL SIGNATURE H. James Kott M.D.				PHYSICIAN'S NAME (Type) H. James Kott			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE APR 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4736

CERTIFICATE OF DEATH

04724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Alleg.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>2102-2</u>	
c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Paint Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise Catherine Zilek</u>		4. DATE OF DEATH <u>April 13</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1883</u> 75 yrs.
9. AGE (In years last birthday) <u>75</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Armbruster</u>		14. MOTHER'S MAIDEN NAME <u>Berk Lear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>15 min.</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 28</u> , 19 <u>59</u> , to <u>April 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>10:20</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. [Signature]</u> M.D.		ADDRESS (Street, city, or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>4-13-59</u>	
PHYSICIAN'S NAME (Type) <u>Talkona Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lees Co.</u> ADDRESS <u>300 4th St. NE. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

